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Art Therapy for Posttraumatic-Stress Disorder

Section A:

A Systematic Literature Review of The Impact of Art Therapy Upon
Posttraumatic-Stress Disorder

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Section B:

“My Heart on This Bit of Paper”:

A Grounded Theory of The Mechanisms of Change in Art Therapy
for Military Veterans

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“It’s all from your past. And it’s all from now, because of your symptoms. Like the symptoms you have of having nightmares, flashbacks. Isolation. All these things, it’s the past and it’s now. Because the past makes the now.”



Acknowledgments

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Summary of MRP Portfolio

Section A details a systematic literature review of the impact of art therapy upon adults with a diagnosis of posttraumatic-stress disorder (PTSD). The review of 14 identified papers is structured into four themes that were identified across the reviewed literature. Overall methodological considerations of the field of study included study design, measures and analysis, researcher biases, and sample size. The review ends with suggestions for further research and clinical practice, based upon review findings in light of the methodological critique.

Section B presents the results of a grounded theory study of veterans' experience of art therapy, its impact upon PTSD, and perceived mechanisms of change of the modality. Semi-structured interviews were conducted with nine veterans, two art therapists, and a veteran's wife. Theorised categories pertaining to active ingredients of art therapy and its impact included (a) the art therapy group, (b) the art therapist, (c) trust, (d) doing the work, (e) a communication tool, (f) points of recognition, (g) making things concrete, and (h) not a cure. The developed model is subsequently linked with existing literature. Limitations are discussed before ending upon clinical and research recommendations.

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Gabriel Schnitzer, BSc (Hons) MSc

Section A: Literature Review

A Systematic Literature Review of The Impact of Art Therapy Upon
Posttraumatic-Stress Disorder

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(excl. title page, abstract, running heads and footers, figures, tables, reference list)

Abstract

Background: Dominant theories of posttraumatic-stress disorder (PTSD) and evidence-based treatments are discussed. A case is made for art therapy and its contributions to the treatment of PTSD. The systematic literature review set out to critically review existing evidence of the impact of art therapy upon adults with a diagnosis of PTSD.

Methodology: Five online databases were searched for articles published in peer-reviewed journals exploring the effectiveness of art therapy in the treatment of PTSD. The search yielded 449 papers. Following application of exclusion criteria 14 were included in the systematic review.

Results: Four themes were identified in the reviewed articles: (1) impact on symptoms, (2) processing traumatic memories, (3) fostering a holistic view of self, and (4) increased well-being and more positive view of self. Overall methodological considerations included issues regarding study design, measures and analysis, researcher biases, sample size, and treatment received.

Discussion: Evidence suggested that some can benefit from the treatment with effects being shown in most symptom clusters of PTSD. Implications such as the need for more robust research in the field are discussed. Clinical recommendations include the suggestion to use art therapy when avoidance or feelings of guilt/shame make engaging in standard talking therapies difficult.

Keywords: systematic review, art therapy, PTSD

Introduction

Psychological Trauma: History and Dominant Theories

In her seminal work *Trauma and Recovery*, Herman posits that trauma is an affliction of powerlessness. The victim of trauma is rendered helpless in the face of an overwhelming force that may be human or that of nature. As a result, the ordinary ways of making sense of the world are challenged or even overridden (1992).

Physicians and more recently neurologists and psychologists have investigated psychological trauma for centuries (Shay, 2002) with scientific literature emerging as early as 1813 (Gailiene, 2011). Since the 19th century the understanding of trauma has changed rapidly and drastically. Diagnoses such as hysteria, *choc nerveux*, traumatic/fight neurosis, soldier's heart, and shell-shock were all early conceptualisations of what we call today posttraumatic-stress disorder (PTSD). For a comprehensive summary of the history of the trauma concept please refer to Weisaeth (2014).

The exposure to actual or threatened death, serious injury, or violence either directly or as a witness is criterion A of PTSD in the latest edition of the Diagnostic Statistical Manual (DSM V; APA, 2013). For a diagnosis, survivors must also show at least one sign of persistent re-living (i.e., nightmares, flashbacks), avoidance of trauma-related stimuli, at least two signs of negative thoughts/feelings (e.g., exaggerated blame of self/others, inability to recall key features of trauma), as well as trauma-related arousal (e.g., hypervigilance, increased startle reaction). Several theories have been proposed to explain the genesis of psychological trauma. The most dominant theories shall now be discussed individually.

Psychodynamic Theories

The first psychological theories of PTSD were developed in the psychoanalytic tradition. Freud (1920) proposed that the psychic system became overloaded by large quantities of 'excitation' from external stimuli. In order to stabilise the system, the psyche is forced into

a repetitive cycle of avoidance/denial and re-living until the trauma is mastered or contained. Since then the psychodynamic literature on trauma has become vast (Nijdam & Wittmann, 2015)¹. Most psychodynamic theories, however, share several key aspects. Firstly, trauma is conceptualised as a subjective experience rather than an objective event. The traumatising potential lies within the relation between the event and previous life experiences, current situation, context, and values (Nijdam & Wittmann, 2015). Secondly, understanding of the survivors object-relations is crucial. Objects are mental representations of the outside world. The most primal objects include a self-representation, a representation of another person (usually based on the primary care-giver), and an affect linking the two (Klein, 1958; Leiper & Maltby, 2004). Laub (2005) posited that trauma caused a rupture in the relationship between the self and the good objects internalised in childhood. Losing the internal object of the empathic other results in a profound feeling of solitude and dreariness and impacts on survivors' ability to verbalise traumatic events in an integrated way (Cohen, 1985). Consequently, the person oscillates between warding off memory fragments and intrusive re-living (Horowitz, 1986). One might wonder why a traumatic experience should rupture the relationship to internalised empathic care-givers, but the primary objects are the templates for any relationship in object-relations theory (Leiper & Maltby, 2004). Serious trauma caused by any person may be powerful enough to alter those early templates. What this theory cannot explain is trauma in response to natural disasters which is unlikely to impact on the primary objects.

¹ For a comprehensive summary of the history of psychodynamic trauma theory please refer to Bohleber (2000).

Models based on Learning Theory

Many etiological theories of PTSD attempted to explain genesis and maintenance of its typical difficulties using learning theory. On the most basic level, Keane and Barlow (2002) hypothesised that exposure to a traumatic event (unconditioned stimulus) triggers a fear or alarm reaction (unconditioned response). Subsequently, people experience similar reactions (conditioned response) to cues associated with the trauma (conditioned stimuli). Such alarm reactions may thus motivate to avoid the re-experience of the conditioned response (negative reinforcement). Conditioning theories have high face validity and convince with simplicity but they fail to recognise the importance of other key emotional reactions such as guilt, shame, and anger (Gillihan, Cahill, & Foa, 2014).

Somewhat more sophisticated are emotional-processing theories. Two premises form their basis. Firstly, PTSD reflects the presence of pathological emotion structures in the person's memory. These may be organised around any strong emotion including fear, shame, guilt, and anger. Such structures include the representation of emotion-laden stimuli, responses, and meanings as well as the associations between those representations. The entire emotion structure is activated when the person faces information that matches some of the representations in the structure thus resulting in a cognitive, behavioural, emotional, and physiological reaction. Secondly, activation of the pathological representations in the emotion structure and subsequent disconfirmation of erroneous anticipation of negative consequences can modify the neuronal network (Gillihan et al., 2014). Such theories not only account for the acquisition of PTSD and efficacy of exposure-based interventions (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010) but also explain the prevalent perception of the world as being entirely dangerous and hostile in response to trauma (e.g., Janoff-Bulman, 1992). A multitude of stimuli can activate the pathological emotion system thus maintaining PTSD symptoms and further reinforcing those core beliefs (Foa, Hembree, & Rothbaum, 2007). The

theory can also explain ‘natural recovery’; the finding that PTSD-like difficulties are common immediately after the experience of trauma but subside rapidly often without intervention (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). Negative assumptions are believed to be disconfirmed through activation of trauma memory in the absence of additional trauma (Foa & Cahill, 2001). Emotion processing theory has great explanatory power yet some aspects have been challenged. A fear neural network which is activated as one may not account for gaps and vagueness in trauma memories (Mechanic, Resick, & Griffin, 1998). The single-level of representation model has furthermore been criticised for failing to distinguish between an emotion-laden and more detached remembering of the trauma (Brewin & Holmes, 2003). Finally, according to the model talking about fear generally should activate the whole trauma network (Barnard & Teasdale, 2014) which seems unlikely (Brewin & Holmes, 2003).

Finally, cognitive theory places emphasis not on the situation itself but the interpretation thereof. The most prominent cognitive model of PTSD has been proposed by Ehlers and Clark (2000) and can be seen as a further development of classical conditioning and emotional-processing theory. In this model, PTSD may only develop if following a traumatic event, the world is perceived as dangerous/hostile or the self as incapable/incompetent/helpless. As the appraisals of the traumatic events take a central role in this model they lead to selective retrieval of information consistent with the appraisals (Buckley, Blanchard, & Neill, 2000). Conversely, information inconsistent with the dominant appraisals will be suppressed (Fleurkens, Rink, & van Minnen, 2011) offering an explanation for disorganised and fragmented memory of the events. Whilst the model offers convincing explanations for all symptom clusters, it is inconsistent with the finding that cognitive re-structuring failed to improve the outcome of exposure therapy (Foa et al., 2005) but addition of exposure generally enhances the efficacy of cognitive therapy (Resick et al., 2008).

Dual-Representation Theory

Brewin and colleagues (Brewin, Dalgleish, & Joseph, 1996) propose in their dual-representation theory that it is not simply the quality of trauma memories that distinguishes them from ordinary memories but that they are processed and represented in distinct neurological networks of the brain. Both systems operate in parallel; during and after the traumatic event. Contextual representations can be communicated verbally and include a narrative of the events as well as any emotions experienced during the trauma. They are stored in the hippocampus integrated with other autobiographical memories. Conversely, sensory-based representations cannot be voluntarily recalled but are triggered by reminders of the trauma. As they cannot be retrieved deliberately they are usually difficult to verbalise and cannot be integrated with other memories. Sensory-based representations account for flashbacks and hyperarousal according to Brewin's theory. Key neurological structures in the sensory-based representation system are the amygdala and insula. Ordinary memories include both contextual and sensory-based representations and connections between them. In contrast, the extreme stress/terror during trauma leads to unusually strong sensory-based representations (e.g., Rauch et al, 1996), dampening of hippocampal activity (Metcalf & Jacobs, 1998), and weakened connections between the two systems (Brewin, Gregory, Lipton, & Burgess, 2010). In the absence of contextual representations any activation of the sensory-based representations will lead to a similar reaction to the time of the trauma resulting in the here-and-now quality of flashbacks. Dual-representation theory appears to be, to-date, the theory that integrates existing scientific research best (Gillihan et al., 2014).

Evidence-based Therapies for PTSD

A number of different psychological treatment options have been proven useful in treating PTSD. Evidence has been established in randomised controlled trials (RCT) as well as meta-analyses. The most commonly used therapies are discussed below.

Cognitive-Behavioural Therapy (CBT)

CBT is a broad category of therapies based on principles of learning, conditioning, and cognitive theory. Various behavioural and/or cognitive techniques are used to impact on bodily reactions and physiological processes by changing thoughts and/or behaviour (Simmons & Griffith, 2014). Prolonged exposure (PE) therapy is based on emotional-processing theory. Central components of the treatment are (a) exposure to traumatic memory *in sensu* by recounting it aloud and (b) *in vivo* exposure by approaching trauma reminders safely. Corrective learning and recovery are thought to occur through the activation of unpleasant emotions in a safe setting and disconfirmation of anticipated harm (McLean, Asnaani, & Foa, 2015). RCTs have attested the effectiveness of PE (McLean & Foa, 2011). Therapeutic gains have been shown to be maintained for up to five years (Powers et al., 2010). A recent meta-analysis showed that, compared to the wait-list condition, 66% more of those who were treated with PE lost their diagnosis of PTSD (Cusack et al., 2016). Despite this impressive track record, not all trauma survivors benefitted from PE. Moreover, Hembree et al. (2003) found an attrition rate of 20-26%.

Cognitive therapy for PTSD (CT-PTSD) is theoretically underpinned by Ehlers and Clark's (2000) model. CT-PTSD aims to (a) modify overly negative appraisals of the traumatic events, (b) decrease re-living by elaboration of trauma memories and discrimination of triggers, and (c) decrease behaviours and cognitions maintaining a sense of acute threat (Ehlers & Wild, 2015). The efficacy of CT-PTSD in the reduction of PTSD symptoms has been attested in several RCTs (Ehlers et al., 2003, 2005, 2014).

Cognitive processing therapy (CPT) is based on the hypothesis that emotional reactions to traumatic events interfere with the emotional and cognitive processing of the events ultimately leading to trauma symptoms (Resnick & Schnicke, 1993 as cited in Cusack et al., 2016). In therapy, beliefs about the meaning of the trauma and its implication for the survivor's

life are addressed via written accounts and cognitive re-structuring (Resnick & Schnicke, 1993). RCTs yielded positive effects of CPT upon PTSD symptoms and other associated psychological difficulties (Resick et al, 2002) with treatment gains sustained over 5-10 years (Resick et al., 2012).

Eye-Movement Desensitisation and Reprocessing Therapy (EMDR)

EMDR is underpinned by neurophysiological findings and appears consistent with dual-representation theory. In a nutshell, the treatment is based on the idea that trauma memories have been dysfunctionally stored and encoded with the original feelings, cognitions, and physical sensations. Traumatic events can overwhelm the information processing system resulting in memories becoming ‘frozen in time’. The aim of EMDR is to help clients re-process their memories by focussing on specific components of the events whilst engaging in bilateral stimulation usually via horizontal eye movements (Shapiro & Lalotis, 2015). EMDR has a strong evidence-base and is one of only two NICE² guidelines (2005) recommended treatments for PTSD. Lee and Cuijpers’ (2013) meta-analysis of 26 RCTs comparing the eye movement component of EMDR with an exposure condition found significantly greater improvements in the eye movement condition. This suggested that the eye movements used in EMDR contributed to its effectiveness over and above the innate *in sensu* exposure to traumatic memories.

Narrative-Exposure Therapy (NET)

NET is based both on cognitive models and on Brewin et al.’s (1996) dual-representation theory. NET aims to strengthen the neuronal connections between

² National Institute for Health and Care Excellence

sensory/perceptual memory and contextual information including a location in time and place (Elbert, Schauer, & Neuner, 2015). This is achieved by constructing a comprehensive chronological narrative of the survivor's life focussing on traumatic experience(s). Systematic reviews and meta-analyses have demonstrated positive treatment effects of NET for a range of traumatic stress experiences and populations (e.g., Cusack et al., 2016; Crumlish & O'Rourke, 2010; McPherson, 2012; Nickerson, Bryant, Silove, & Steel, 2011; Robjant & Fazel, 2010). Both NET and EMDR appear to tap into the neuronal mechanisms. Both interventions attempt to re-connect sensory-based and contextual representations of trauma. This might explain similarly convincing evidence found for both approaches. Unfortunately, to the best of the author's knowledge comparative studies regarding the efficacy of NET and EMDR have not been conducted.

Psychodynamic Psychotherapy

The landscape of psychodynamically-informed psychotherapies is vast and each approach focuses on different aspects of the human psyche and utilises different techniques (Lemma, 2016). Perhaps the most fundamental idea that psychodynamic therapies share is the focus on psychological pain or anxiety. It is believed that people are motivated to avoid such pain by using a range of defence mechanisms that often operate outside conscious awareness. These defences may manifest in terms of seeing, feeling, or behaving in a certain way and thus creating a mismatch between external reality and internal perception of the world. Whilst those mechanisms of defence are normal and adaptive in order to function in society they can become ineffective or unhelpful in turn leading to distress (Leiper & Maltby, 2004). A number of PTSD-specific treatment approaches were developed geared towards the specific nature and manifestation of psychic conflicts in PTSD (e.g., Krupnick, 2002; Lindy, 1993; Wöller, Leichenring, Leweke, & Kruse, 2012). Although largely understudied (Cloitre, 2009) psychodynamic interventions in treating PTSD appear to be used frequently in clinical practice

(Schottenbauer, Arnkoff, Glass, & Gray, 2006) and some research has suggested beneficial effects (Brom, Kleber, & Defares, 1989).

A Case for Alternatives

Whilst comparative effectiveness has not been established to a satisfying degree (Cusack et al., 2016), the above cited literature highlights the broad landscape of available treatment options for trauma survivors. This may raise the question of why alternative approaches are needed or existing techniques should be modified. It is, however, clear that there is no therapy that yielded a perfect success rate and research has found up to 30% of service-users to be unresponsive to evidence-based treatments (Wisco, Marx, & Keane, 2012). Additionally, a recent meta-analysis yielded drop-out rates as high as 36% for PTSD psychotherapies (Goetter et al., 2015), suggesting that some could not benefit from or were not satisfied with the treatment received. Furthermore, most people with PTSD have additional difficulties such as depression or substance abuse (e.g., Brown, Campbell, Lehman, Grisham, & Mancill, 2001). Those people are often excluded from clinical trials (Westen, Novotny, & Thompson-Brenner, 2004) thus not reflecting the population commonly seen in mental health services. Lab, Santos, and DeZuleta (2008) also noted that stringent use of NICE recommended treatment options often did not lead to recovery. This might be due to the finding that service users' preferences for treatment impacted upon treatment adherence and outcome (Lin et al., 2005; Van et al., 2009). Finally, whilst some therapies have been evaluated in non-Western cultures (NET: e.g., Hijazi et al., 2014; Zang, Hunt, & Cox, 2013; CBT: e.g., Bass et al., 2013) the majority of clinical trials have been conducted in Western developed countries.

Art Therapy

Many struggle to access traumatic memories verbally (Johnsen & Asbjørnsen, 2008). Art therapy (AT) might offer a viable treatment option for some of those who are less able to

benefit from commonly used interventions by offering a non-verbal route to explore aspects around traumatic experiences.

The British Association of Art Therapists (BAAT) define art therapy as a form of psychotherapy that uses art media as its primary mode of expression and communication. Within AT, art is used as a medium to address distress. Although primarily influenced by psychodynamic concepts, art therapists have incorporated a host of other psychological approaches in their work such as attachment, mindfulness, compassion-focussed, cognitive analytic, and to a lesser extent neuro-scientific findings (BAAT, 2017). It is offered both as group and individual intervention.

AT sessions normally consist of two separated parts. In the first phase, participants produce artwork freely and independently. In the second phase, the art pieces are reviewed. Participants verbalise what they had attempted to convey or what they can see in the finished piece. Alongside the therapist, elements of the artwork are interpreted and made sense of in the context of the service-user's life (Case & Dalley, 2014). The landscape of currently used art therapy approaches is vast. Divergences are based on underlying theoretical orientation and degrees of directiveness exhibited by art therapists (e.g., use of themes or specific art materials). In attempts to homogenise the field, some art therapists rely on specifically developed manuals such as the art therapy trauma protocol (ATTP; Talwar, 2007). Suggestions have also been made as to how to interpret certain symbols appearing in service-users' artwork (e.g., Schaverien, 1992). Nevertheless, many art therapists continue to work flexibly and openly (Case & Dalley, 2014).

Evidence-base of Art Therapy

Potash, Mann, Martinez, Roach, and Wallace (2016) systematically reviewed the use of AT in the mental health context. The authors concluded that AT is used in a variety of settings to alleviate distress resulting from a wide range of conditions. Scope, Uttley, and

Sutton (2017) systematically reviewed qualitative studies on AT for non-psychotic disorders. Benefits included the development of relationships to the therapist and group members, personal achievement, empowerment, and increased insight. Uttley et al. (2015) conducted an extensive systematic review of quantitative and qualitative studies. Out of 15 RCTs exploring the effectiveness of AT in a variety of health settings (i.e., depression, physical health, dementia) 10 reported positive changes in mental health symptoms compared to the control condition. Four studies reported a significant improvement but no difference to the control group. One study favoured control. A recent methodologically robust RCT comparing the impact of a clay-based AT group with visual arts control by Nan and Ho (2017) suggested that AT was more effective than the control condition in reducing depression and improving general mental health and well-being in their sample of 106 people with depression. Despite these promising findings regarding the effectiveness of AT in various settings and presentations, AT has been criticised for lacking rigorous study design and evidence (Ebmeier, Donaghey, & Steele, 2006; Kimport & Robins, 2012; Rose, Aiken, & McColl, 2014).

AT and Dominant Psychological Theories of Trauma

AT is frequently used as an intervention for trauma (Potash et al., 2016). Particularly traumatised children have been reported to benefit from AT (O'Brien, 2004; Malchiodi, 2012). A number of the above cited psychological theories of trauma may underlie the mechanisms of change in AT. On the most basic level, AT's effectiveness may be explained by Keane and Barlow's conditioning theory (2002). Spaletto (1992) suggest that art therapy may offer an opportunity for exposure to trauma cues in a safe way. Survivors may subsequently habituate to conditioned stimuli. Moreover, AT may support participants in finding meaning in the horrifying events by an invitation to look at what had occurred from different angles and by bringing in a future/coping/compassion-oriented perspective akin to psychodynamic theories around the centrality of meaning of events to the survivor (Nijdam & Wittmann, 2015).

Furthermore, Bion's concept of containment (1970) may offer insight into the mechanisms of art therapy. As part of psychodynamic psychotherapy the analyst provides containment so that clients can experience a fuller range and depth of thoughts and feelings in order to work on them (Sarnat, 2010). Artwork might function as a 'container' for difficult feelings by offering an opportunity to (partially) project them into it and explore them on its surface (Litz et al., 2009). Additionally, emotional-processing theories may support the use of AT for PTSD. Working on certain aspects of the trauma memory by means of art-making may activate relevant emotion structures in a safe and calm environment thus disconfirming erroneous assumptions.

Possibly the most relevant theory is Brewin et al.'s dual-representation theory (1996). The structure of AT plays to both representation systems in the brain. In the art-making part non-verbal memories are tapped into and explored (sensory-based representations). In the second part, through verbal elaboration and interpretation those areas involved in contextual representations are engaged. The two memory systems may subsequently reconnect (Gantt & Tinnin, 2009). Bolwerk, Mack-Andrick, Lang, Dörfler, and Maihöfner (2014) used brain imaging techniques to show an increase in functional connectivity between the posterior cingulate cortex and the frontal and parietal cortices in an art-making group and compared to an art evaluation control group. Caveats of these studies were the use of a non-clinical sample and short follow-up period.

Aims of Review

AT is used in the treatment of a range of psychological difficulties but its impact on adult trauma survivors has not been reviewed in a systematic way. The current systematic review aimed to explore the reported effects of AT upon adults with a diagnosis of PTSD.

Methodology

A systematic literature review was undertaken to answer the above stated review question. It was decided to search five literature data bases namely PsychInfo, ASSIA, Medline, PILOTS, and ERIC. The search terms used were:

1. art therap* OR creative art* therap* OR art making OR art-making OR art-based therap* OR art based therap* OR drawing* OR painting* OR sculptur*
AND
2. posttraumatic stress* OR post-traumatic stress* OR post traumatic stress* OR PTSD OR acute stress* OR emotional trauma* OR combat stress

Inclusion and Exclusion Criteria

Papers published in peer-reviewed journals exploring the effectiveness or efficacy of art therapy in the treatment of adults (aged 18 and above) with a formal diagnosis of PTSD were included. Non-English articles were excluded. It was decided to exclude therapeutic interventions using creative writing or drama therapy to capture the non-verbal element of AT. Articles solely pertaining to theory without detailing either new research findings or systematic review of previous research were also excluded. As traumatic experiences in childhood or adolescence appear to have particular implications for complexity and severity of trauma symptoms in adulthood (Cloitre et al., 2009; Briere, Kaltman, & Green, 2008; Van der Kolk, Roth, Pelcovitz, Sundaz, & Spinazzola, 2005) AT interventions with adults whose index trauma occurred before reaching adulthood were excluded. It must be noted that some might have had a history of childhood trauma that was not investigated and/or reported by the authors.

Quality Appraisal Tools

To guide the review and aid critique of the identified articles quality appraisal tools were used. Yin's (2014) criteria were used to judge the quality of case-studies. Qualitative studies and systematic reviews were assessed with the corresponding check-list by the Critical

Appraisal Skills Programme (CASP). Pluye, Gagnon, Griffiths, and Johnson-Lafleur's (2009) quality framework was used to critique mixed methods research.

Results

Systematic Literature Search

Please refer to Figure 1 for a flow-chart of the systematic literature search process.

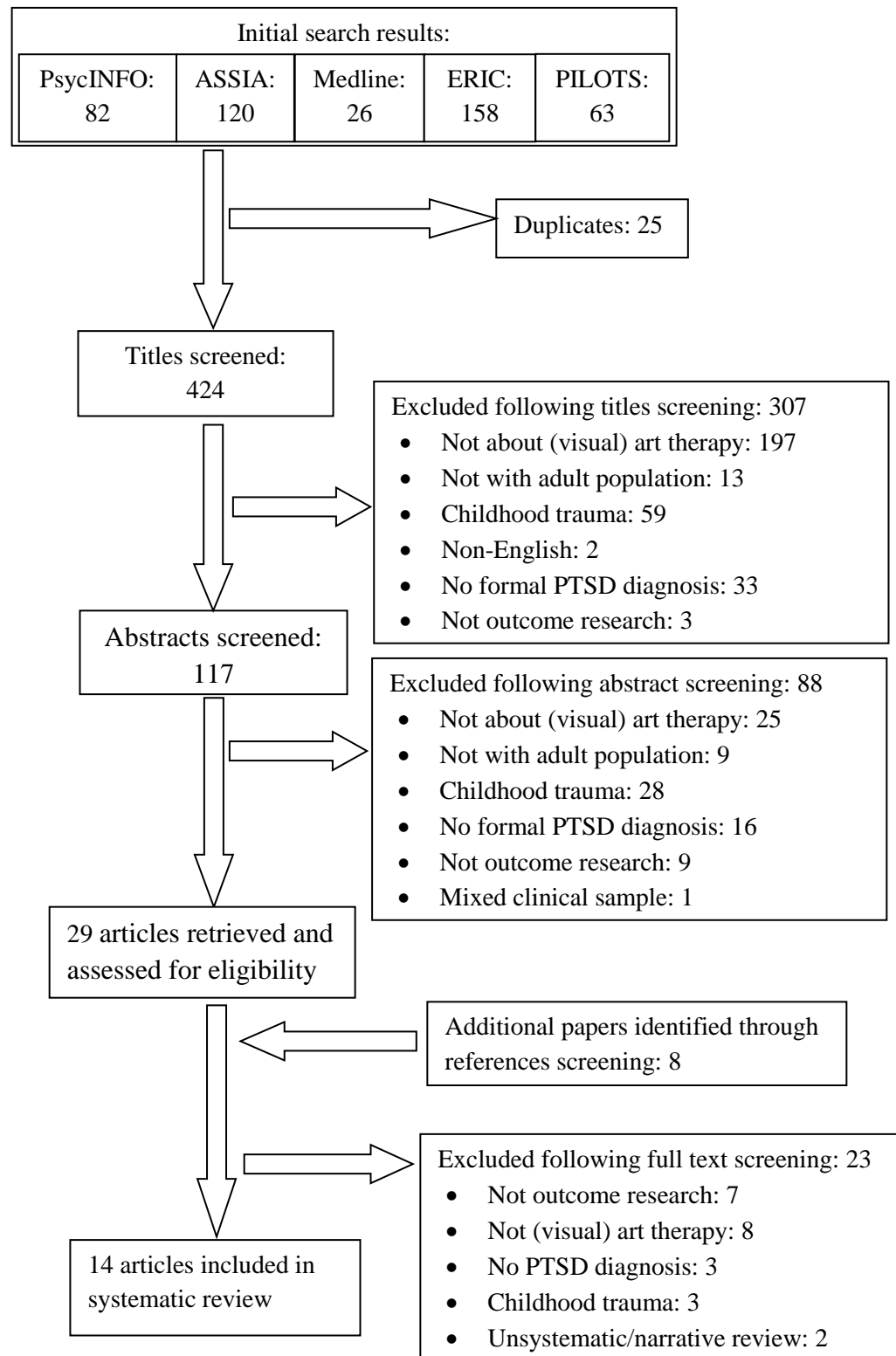


Figure 1. Flow-chart of the systematic literature search process

Identified Papers

Table 1 presents a summary of the papers included in the systematic review.

Table 1.

Summary of identified papers. Those papers that are discussed together in the main body are presented together in this table.

Study	Design	Participant(s)	Intervention	Outcomes
Avrahami (2005)	2 case-studies	1: 65 yr old male veteran 2: 58 yr old male veteran	Weekly individual AT for 6 months Clearly described and theory-driven	Anecdotal: 1: filling gaps in trauma memories; building confidence to talk about trauma; fostering hope; integration and empowerment; more healthy aspects of personality (humour, joy, colourfulness) to come back to the fore; address feelings of (dis-) trust in transference; re-connecting with feelings; 2: processing trauma memories; expression of emotions connected to trauma (depression, sorrow, anger, confusion, missing out); created distance to trauma by use of different perspectives; brought forth positive life memories; integration of trauma into narrative
Berkowitz (1990)	Single case-study	41 yr old African American veteran with PTSD and diagnosis of schizophrenia	Individual AT for over 1 year Not clearly described and not theory-driven	Anecdotal: helped client to talk about difficulties; enabled connecting with trauma instead of 'avoidance'; development of more holistic view of self and own past; verbalising feelings about the past
Fitzpatrick (2002)	Single case-study	38 yr old female Bosnian refugee	4 individual AT sessions Clearly described but not theory-driven	Anecdotal: reconstruction of lost trauma memories; sense of control over the past; increased ability to tolerate trauma memories; enhanced well-being (i.e. sense of identity, self-efficacy, courage)
Hass-Cohen, Findlay, Carr, & Vanderlan (2014)	Single case-study	Female witness of 9/11 terror attack	Individual protocol-based AT in 5 stages Clearly described and theory-driven	Quantitative: BAI dropped below clinical level; on CES increased insight and decreased avoidance, optimism, hope for future amongst others Anecdotal: feeling more present; more attuned to child and husband; improved communication; trauma less frequently part of outlook on future; support in symbolising memory
Lamont, Brunero, & Sutton (2009)	Single case-study	46 yr old female with borderline PD and PTSD	11 sessions of AT as part of inpatient admission (clearly described but not theory-driven); psychopharmacological treatment alongside	Anecdotal: relief of previous traumatic events; externalising thoughts and feelings; explore thoughts + feelings in structured non-blaming way; development of ability to distract from intense feelings; engagement with staff in non-confrontational way

Mims (2015)	2 case-studies	1: 50 yr old male homeless African American veteran with PTSD, anxiety, depression 2: 25 yr old female homeless veteran of mixed White and Latin America background. Diagnoses of PTSD, anxiety, depression	6 weeks of group visual journaling AT Clearly described but not theory-driven	Quantitative: no change in CORE-OM scores over course of treatment Thematic analysis: 1) increased self-knowledge 2) therapist qualities 3) group vs individual therapy 4) art making benefits 5) art communicates the “real” me
Merriam (1998)	4 case-studies	4 female prisoners: 1: 19 yr old Native American with PTSD, schizophrenia, PD, and substance abuse 2: 24 yr old with PTSD and PD 3: 24 yr old with PTSD and eating disorder 4: 22 yr old with PTSD	Individual AT in prison; amount of sessions and length of intervention not specified Not clearly described but theory-driven	Anecdotal: women were provided with encounter of inner experience; more complete understanding of themselves was reached without feeling exposed; artwork acted as ‘container’ for powerful and potentially destructive emotions
Morgan & Johnson (1995)	2 case studies	42 and 44 yr old Vietnam veteran with PTSD and combat nightmares	Residential 16-week PTSD programme; 4 3-week intervals of either drawing of or writing about nightmares if and when they occurred; 2 permutations (ABAB, BABA); clearly described and theory-driven	Quantitative: nightmare frequency and intensity decreases in drawing but not in writing task; more sleep problems and startle in writing condition; finding consistent in both permutations; no difference between participants but significant difference in mean scores between conditions
Allen & Wozniak (2011)	Mixed methods uncontrolled pre-/post study	11 female survivors of domestic violence; 2 groups facilitated at 2 treatment centres; mean age: 35	10-week eclectic treatment package including AT (not clearly described and not theory-driven), yoga, mindfulness/ meditation, psycho-education	Quantitative: significant reduction in PTSD checklist scores pre- to post on 8 out of 11 items; Qualitative: 6 themes found in grounded theory: creating safe place, establishing autonomy, pride in appearance, reclaiming self, developing inner peace and serenity, re-joining community
Campbell, Decker, Kruk, & Deaver (2016)	Mixed methods randomised controlled	15 male veterans (5 in experimental, 10 in control condition)	Residential programme; intervention: 6 sessions of AT (clearly described and theory-driven) and CPT; control: CPT only	Quantitative: significant improvement on PCL-M in both groups (no between group differences); significant improvement in BDI scores (no between group differences) Content analysis: (1) AT helps working through avoidance (2) AT provides positive form of expression of painful emotions (3) AT assisted in understanding traumatic experiences (4) high degree of satisfaction with AT

Gantt & Tinnin (2007)	Uncontrolled pre-/post study	72 participants; 77% female; mean age 38	Intensive outpatient programme for 1-2 weeks; 7 hours of therapy a day; treatment package with psycho-education, narrative trauma processing, AT (not clearly described and not theory-driven); group and individual sessions	Quantitative: significant improvement on IES, SCL-45, DES, and TAS over course of treatment
Lobban (2012)	Qualitative study using focus group	5 veterans	2 weeks admission with group AT as component of treatment package Clearly described and theory-driven	Thematic analysis: (1) problem areas of a) disconnection, b) control and avoidance, c) false self, d) stuckness in traumatic memories; (2) during AT participants a) felt connected, b) worked spontaneously, c) opened up, d) processed material
Johnson, Lubin, James, & Hale (1997)	Naturalistic cohort study	Two cohorts of 12 and 13 Vietnam veterans; 100% male; mean age 40.2 yrs	16-week residential treatment programme; comparison of single session effects of 15 treatment components AT not clearly described and not theory-driven	Quantitative: correlation between PTSD symptom severity and achieved change (but not with state PTSD pre or post) with higher scores generally resulting in less change; paired samples t-tests showed significant improvement following 3 out of 15 components (AT being one of them); two-factor ANOVAs with high and low PTSD score at admission and current experience of PTSD symptoms at two time points (before and after the session) showed significant interaction term with only AT showing the opposite direction (i.e., higher severity larger change)
Schouten, Gerrit, Knipscheer, Kleber, & Hutschemaekers (2015)	Systematic review	6 controlled studies with adult participants included (total intervention group n= 102; total control group n=120)	2 studies AT in combination with other therapies; 4 studies AT only; 3 studies on mandala drawing; 3 studies on group AT Not clearly described and unclear whether or not theory-driven	50% of studies found improvement in utilised trauma measures; 1 study found decrease in depression

Notes. AT=art therapy. ANOVA=analysis of variance. BAI=Becks Anxiety Inventory. BDI= Becks Depression Inventory. CES=centrality of event scale. CORE-OM=clinical outcomes in routine evaluation-outcome measure. CPT=cognitive processing therapy. DES= dissociative experience scale. IES= impact of event scale. PCL-M= PTSD checklist-military version. PD=personality disorder. PTSD=posttraumatic-stress disorder. SCL-45= symptom check list-45. TAS= Toronto alexithymia scale. None of the studies included in Schouten et al. (2015) were included in the current review. Please refer to 3.3.1.4 for the rationale.

Effects of AT in the Treatment of PTSD

Several outcomes were identified across the reviewed papers. Within the following sections on each of these, studies using similar research designs shall be discussed together.

Impact on Symptoms

Case-studies

The literature search identified seven relevant case-studies. Three of those presented anecdotal changes in PTSD symptomatology, particularly avoidance and social withdrawal. Fitzpatrick (2002) reported that her participants were better able to tolerate memories of and feelings associated with traumatic events. Similarly, a veteran in another case-study (Berkowitz, 1990) reported that he was more able to connect with his trauma and talk about his experiences rather than avoiding them. Moreover, prison staff experienced the female participants in Merriam's (1998) series of case-studies as less socially and emotionally withdrawn following their course of AT.

Additionally, two case-studies reported quantitative data. Morgan and Johnson's (1995) study suggested fewer and less intense nightmares as well as less sleep difficulty and reduced startle reflex. These improvements were found in a drawing but not in the writing condition. Unusual for a case-study, the researchers conducted a 2-factor ANOVA. Analysis yielded a significant main effect of experimental condition. The interaction term, however, did not reach statistical significance. The analysis was, however, hopelessly underpowered with a sample of $n=2$.

The only case-study using standardised tests found decreased avoidance and social withdrawal (Hass-Cohen et al., 2014). However, the paper failed to support their claims statistically. Hass-Cohen and colleagues omitted to report the pre- and post-scores on Beck Anxiety Index (Beck, Epstein, Brown, & Steer, 1988) and Centrality of Event Scale (Berntsen

& Rubin, 2006) as well as whether or not the change was greater than the reliable change index³ of the measures.

Qualitative/Mixed-methods

Five papers used either a qualitative or mixed-methods design. Mims (2015) evaluated in her mixed methods pre-/post study the effects of a six-week visual journaling AT group with veterans. No change in mean CORE-OM⁴ (Barkham et al., 2010) scores could be statistically supported. It must, however, be noted that the sample of two participants was far too small to establish any statistically significant group differences. CORE-OM can furthermore be interpreted in terms of reliable change; however, the researcher failed to do so.

Another study explored the impact of a 10-week integrative group intervention for female survivors of domestic violence with PTSD (Allen & Wozniak, 2011). Narrative ideas formed the basis of the intervention incorporating art therapy, meditation, yoga, and psycho-education. The effectiveness of the programme was tested in two multi-site groups of eleven women altogether. A significant decrease in PTSD checklist (Weathers, Litz, Herman, & Keane, 1994) scores over the course of treatment was found on 8 of 17 items. It was unclear why the researchers chose to analyse the outcome measure by item rather than total score or symptom cluster level. As part of the qualitative component of their study, Allen and Wozniak identified a theme of ‘re-joining the community’ as a requisite for healing. Participants indicated that the group enabled them to break their social isolation and withdrawal. It is important to note that the impact of the treatment package as a whole was investigated.

³ Reliable change refers to any change in scores beyond the expected measurement variability related to the tool’s reliability.

⁴ The Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM) is one of the most widely used outcome measures in the UK (Barkham et al., 2010).

Consequently, it was impossible to attribute any achieved change to individual components of the programme.

A similar design was used by Gantt and Tinnin (2007) who explored the effects of a 1-2 week intensive outpatient treatment for people with trauma-related disorders. A significant reduction in symptoms of PTSD, dissociation, and alexithymia was reported using a battery of standardised and purpose-developed tests. The study, however, had a number of methodological flaws. Most importantly, the lack of control group and use of other interventions made it impossible to attribute changes to the AT component of the treatment package.

Campbell et al. (2016) conducted an RCT with quantitative and qualitative analyses. The researchers investigated whether a combination of AT and CPT yielded better treatment results than CPT on its own in a sample of veterans. Both groups improved in terms of posttraumatic-stress and depression. However, no between group differences were found. This might have been due to the small sample sizes in the experimental ($n=5$) and in the control condition ($n=10$). Between group differences in terms of depression came close to the significance level and a small effect size was reported. This might suggest that the difference between control and experimental conditions would have been statistically significant in a larger sample. In their content analysis of semi-structured interview data Campbell et al. (2016) reported a positive impact of AT upon veterans through decreasing avoidance due to the non-verbal nature of the therapy.

Finally, Lobban (2012) reported the theme of 'opening-up'. Veterans attending group art therapy talked about exploring (aspects of) traumatic events on the surface of artwork. This was found to be spontaneous, somewhat distant, and non-threatening thus bypassing a need to control and avoid feelings. In addition, 'feeling connected' both to their own experiences and

each other was identified as a beneficial impact of art therapy counteracting feelings of isolation.

Quantitative Studies

One quantitative study was identified. Johnson et al. (1997) compared the single session effectiveness of 15 treatment components of a 16-week multi-disciplinary admission for veterans with PTSD. A purposely designed tool measuring current PTSD symptoms was administered before and after sessions. Improvements were third greatest following art therapy. It was, however, unclear why the researchers developed their own measures rather than to rely on standardised and validated tools. Reference to how the measures were developed and copies of the questionnaires would have been helpful. Another important caveat was that due to complexity of the model, researchers were unable to compare the effects of the interventions. Instead it was necessary to create categories. Categories were described but the authors omitted to state in which category each intervention fell. Interestingly, contrary to the other interventions, 2-factor ANOVAs showed greater improvement in those with a higher level of difficulties following AT. A medium effect size was reported. This suggested that art therapy may be particularly helpful for those with the most severe difficulties. All findings were replicated in a second cohort.

Systematic Reviews

Schouten et al.'s (2015) review was the only included systematic review. They set out to determine the effectiveness of AT in controlled studies. Significant decrease in symptoms of trauma was reported in 50% of included studies. One paper additionally reported positive impact on symptoms of depression compared to controls. It must, however, be noted that only six studies were found with medium quality ratings, two of which were unpublished theses. Furthermore, Schouten's definition of AT can only be described as broad as half of the papers

used mandala drawing rather than AT as defined by BAAT (see above). None of the studies included in the review were considered here as the remaining study was published in Dutch.

Processing Traumatic Memories

It has been hypothesised that AT may help in processing memories (Langer, 2011; Talwar, 2007). For the purpose of this review, ‘processing traumatic memories’ subsumes the retrieval of aspects of trauma memory that had been blocked (i.e., specific details, emotional reaction during the events) as well as working through residual feelings survivors were left with and being able to file the traumatic experience in the past.

Case-studies

Five case-studies detailed an impact of AT upon trauma memories. Merriam (1998) observed one of the female prisoners to gain knowledge about the traumatic events that had been inaccessible before. She graphically depicted images of the events that she could not remember and felt disconnected to. Over time she was able to assimilate those buried memories. In Berkowitz’ (1990) case example a Vietnam veteran reported the retrieval of missions during his deployment as well as situations with a friend who had died in the war which he claimed to have forgotten. Whilst this was mirrored in Avrahami’s (2005) sample, evidence appeared somewhat more compelling as newly surfaced material was shown both in various artworks and highlighted with quotes from participants. Both cases reported not only to remember certain situational details of the traumatic event but also emotional content. The latter finding was also discussed by Lamont et al. (2009) whose participant reported to be able to connect with feelings of fear, anger, and humiliation experienced at the time of the trauma. In another case-study a war refugee experienced a “flood of memories” (Fitzpatrick, 2002, p. 156) during an AT session some of which had been inaccessible previously. However, it must be noted that the reported effects were merely anecdotal. No systematic qualitative methods appeared to have been used.

Qualitative/Mixed-methods

Lobban (2012) used thematic analysis to analyse a focus group of five completers of a residential treatment including AT. Amongst other beneficial effects, the veterans talked about the art-making process triggering a chain reaction in which details of the trauma were uncovered, new ways of articulating and thinking about the events explored, and new meaning/understanding was developed. This process was reported to be carried over beyond the AT session into veterans' private life.

The qualitative component of Campbell et al.'s (2016) mixed methods study suggested that participants in the CPT plus AT condition were supported in recovering previously blocked memories by art-making. This finding should, however, be interpreted with caution as only those in the experimental condition were interviewed. It is possible that veterans receiving CPT only also recovered blocked memories.

Fostering a Holistic View of Self

AT was furthermore reported to foster a more holistic view of the self enabling the acknowledgement and integration of aspects of the self that may be hidden or avoided.

Case-studies

The Bosnian refugee who worked with Fitzpatrick (2002) was reported to have developed an enhanced sense of identity over the course of the art therapy intervention. Avrahami's (2005) service-users seemed to undergo an integration process wherein elements of the inner world surfaced as part of the artwork. Through the interpretative part of AT both participants were able to link symbols to their lives and support network. In doing so, service-users managed to reconstruct their biographical sequence and re-evaluate their aspirations and meaningful relationships. Merriam (1998) discussed these processes in the richest detail. On one hand, it was found that the above described retrieval of buried memories aided a better understanding of the present self. On the other hand, service-users were able to experience a

direct and rich encounter with their inner worlds particularly their emotions by means of art-making. Emotions other than anger were said to be generally avoided outside the AT session. Participants learned to access their own feelings, acknowledge, and begin to accept them thus strengthening the newly developed understanding of the self further. Keeping the above mentioned methodological short-comings in mind, Hass-Cohen et al. (2014) reported increased insight and positive shifts on self-knowledge on the Centrality of Event Scale.

Qualitative/Mixed-methods

Mims (2015) identified the theme of ‘increased self-knowledge’ in the qualitative part of her study. For her participants this meant a better understanding of their own emotional reactions as well as their own strengths and resources. Additionally, Lobban (2012) produced a theme of ‘connectedness’ from her data. Veterans talked about translating their feelings and bodily sensations into words via art-making. In doing so, they reported to be able to make sense of their experiences and to find new meanings.

Allen and Wozniak (2011) reported the theme of ‘reclamation of self’ in their grounded theory. The investigated treatment package enabled the survivors of domestic violence to integrate their past and present, re-discover neglected skills and hobbies, and to view themselves as more than simply in the context of trauma. However, an important limitation of the study was that the researchers failed to describe their data analysis exhaustively. Whilst it was referred to as grounded theory methodology the findings presented appeared more in line with thematic analysis as the analysis was not directed towards theory development (Holloway & Todres, 2003).

Increasing Well-being and More Positive View of Self

Case-studies

Fitzpatrick (2002) reported that her intervention fostered a sense of control over memories, emotions, and her participant’s life. The therapist observed the refugee’s overall

well-being and self-efficacy to improve over time. Similarly, autonomy and self-esteem was observed to be strengthened in Merriam's (1998) sample. The artwork of Lamont et al.'s (2009) client suggested that she was better able to distract away from intense feelings. Staff reported her to engage in more non-confrontational interactions. Hass-Cohen et al. (2014) reported an improvement in terms of optimism and hope for the future on the Centrality of Event Scale post-treatment.

Qualitative/Mixed-methods

Arguably, the calming effect reported by Mims (2015) was likely to have had beneficial impact on participants' well-being. Most of the themes identified by Allen and Wozniak (2011) could be categorised as increased well-being and improved self-image. Interview and focus group participants talked about 'creating a safe place' in their homes, a new found 'pride in appearance', as well as 'developing inner peace and serenity'. All of these reported treatment effects were described as supporting participants in their healing process.

Overall Methodological Considerations

Overall the quality of studies was poor as measured by the appropriate critical appraisal tools (Tables 2-6). General methodological short-comings of the research area shall now be discussed.

Table 2.

Quality appraisal of identified case-studies (Yin, 2014)

Author (year)	Construct validity (max. 3 points)	Internal validity (max. 5 points)	External validity	Reliability (max. 2 points)	Total score
Avrahami (2005)	a) Multiple sources of evidence: Yes b) Chain of evidence: No c) Informants reviewed draft: Unclear	a) Pattern matching: Yes b) Explanation building: No c) Rival explanations: No d) Use of logic models: No e) Replication logic used (in multiple case studies): Yes	Theory used (in single case studies): N/A	a) Use of case study protocol: No b) Case study data-base developed: No	3
Berkowitz (1990)	a) Multiple sources of evidence: No b) Chain of evidence: No c) Informants reviewed draft: Unclear	a) Pattern matching: No b) Explanation building: No c) Rival explanations: No (some mentioned in discussion but not investigated) d) Use of logic models: No e) Replication logic used (in multiple case studies): N/A	Theory used (in single case studies): No	a) Use of case study protocol: No b) Case study data-base developed: No	0
Fitzpatrick (2002)	a) Multiple sources of evidence: Yes b) Chain of evidence: No c) Informants reviewed draft: Unclear	a) Pattern matching: Yes b) Explanation building: No c) Rival explanations: No d) Use of logic models: No e) Replication logic used (in multiple case studies): N/A	Theory used (in single case studies): Yes	a) Use of case study protocol: No b) Case study data-base developed: No	3
Hass-Cohen et al. (2014)	a) Multiple sources of evidence: Yes b) Chain of evidence: Yes c) Informants reviewed draft: Unclear	a) Pattern matching: Yes b) Explanation building: No c) Rival explanations: No d) Use of logic models: No e) Replication logic used (in multiple case studies): N/A	Theory used (in single case studies): Yes	a) Use of case study protocol: Yes b) Case study data-base developed: No	5

Lamont (2009)	a) Multiple sources of evidence: Yes b) Chain of evidence: Yes c) Informants reviewed draft: Yes	a) Pattern matching: No b) Explanation building: No c) Rival explanations: No d) Use of logic models: No e) Replication logic used (only for multiple case studies): N/A	Theory used (only for single case studies): Yes	a) Use of case study protocol: Yes b) Case study data-base developed: No	5
Merriam (1998)	a) Multiple sources of evidence: No b) Chain of evidence: No c) Informants reviewed draft: Unclear	a) Pattern matching: Yes b) Explanation building: No c) Rival explanations: No d) Use of logic models: No e) Replication logic used: Yes	Theory used (only for single case studies): N/A	a) Use of case study protocol: No b) Case study data-base developed: No	2

Table 3.

Quality appraisal of identified qualitative studies (CASP, 2013b)

<u>Author (year)</u>	<u>(A) Validity of results (max. 7 points)</u>	<u>(B) Results (max. 2 points)</u>	<u>(C) Generalisability</u>	<u>Score</u>
Lobban (2012)	1. Statement of aims? No 2. Qualitative method appropriate? Can't tell 3. Design appropriate to address aims? Can't tell 4. Recruitment appropriate to address aims? No 5. Data collection consistent with research question? No 6. Relationship between researcher and participant considered? No 7. Ethical issues considered/taken into account? Yes	8. Analysis rigorous? No 9. Clear statements? No	10. Findings valuable? Yes	2

Note. In terms of the reported scores, only meeting the criteria fully was rewarded a point.

Table 4.

Quality appraisal of identified mixed methods studies (Pluye et al., 2009)

Author (year)	<u>1. Qualitative (max. 6 points)</u>						<u>Score</u>
Allen & Wozniak (2011)	1a. Qualitative objective/question Yes	1b. Appropriate qualitative approach/design/method Yes	1c. Description of context Yes	1d. Description of participants and justification of sampling No	1e. Description of qualitative data collection/analysis Yes	1f. Discussion of researchers' reflexivity No	7
	<u>2. Quantitative experimental (max. 3 points)</u>						
	2a. Appropriate sequence generation and/or randomisation Yes	2b. Allocation concealment/blinding No	2c. Attrition Yes				
	<u>3. Mixed Methods (max. 3 points)</u>						
	3a. Mixed methods justified Yes	3b. Combination of qualitative and quantitative data collection/analysis/procedures No	3c. Integration of qualitative and quantitative data/results No				
Campbell et al. (2016)	1a. Yes 2a. Yes 3a. Yes	1b. Yes 2b. No 3b. Yes	1c. Yes 2c. No 3c. Yes	1d. Partly	1e. Partly	1f. Yes	8
Mims (2015)	1a. Yes	1b. Yes	1c. Yes	1d. Partly	1e. Yes	1f. No	8
	<u>2. Quantitative observational</u>						
	2a. Appropriate sampling and sample No	2b. Justification of measures Yes	2c. Control of confounding variables No				
	3a. Yes	3b. Yes	3c. Yes				

Note. In terms of the reported scores, only meeting the criteria fully was awarded a point.

Table 5.

Quality appraisal of identified cohort studies (CASP, 2013a)

<u>Author (year)</u>	<u>(A) Validity of results (max. 8 points)</u>	<u>(B) Results</u>	<u>(C) Generalisability (max. 2 points)</u>	<u>Score</u>
Johnson et al. (1997)	1. Clearly focussed? Yes 2. Cohort recruited in acceptable way? Yes 3. Exposure accurately measures (biases minimised)? Yes 4. Outcome accurately measured (biases minimised)? No 5a. Sufficient confounding variables identified? No 5b. Confounding variables taken into account? Yes 6a. Complete enough follow-up? Yes 6b. Long enough follow-up? Yes	9. Believable results? Yes	10. Applicable to local population? Yes 11. Results fit with other evidence? Yes	9

Note. In terms of the reported scores, only meeting the criteria fully was rewarded a point. Only those items that can be scored are reported here.

Table 6.

Quality appraisal of identified systematic reviews (CASP, 2013c)

<u>Author (year)</u>	<u>(A) Validity of results (max. 5 points)</u>	<u>(C) Generalisability (max. 3 points)</u>	<u>Score</u>
Schouten et al. (2015)	1. Clearly focussed? Yes 2. Right type of papers included? Yes 3. All important/relevant studies included? No 4. Quality rigorously assessed? No 5. Results combined (where indicated)? Not indicated	8. Applicable to local population? No 9. All important outcomes considered? No 10. Benefits outweigh harm/cost? Can't tell	2

Note. In terms of the reported scores, only meeting the criteria fully was rewarded a point. Only those items that can be scored are reported here.

Study Design

The majority of identified papers detailed case-studies which are generally considered the least robust research design. Case-studies are useful in the early stages of research as they have the potential to generate hypotheses. However, internal validity is low. Yin (2014) proposed the use of *a priori* designed comprehensive study protocols and case-study data-bases to increase generalisability and reliability. Only Hass-Cohen et al. (2011) and Lamont et al. (2009) took some steps towards achieving this. Conversely, it must be noted that particularly narrative case-studies possess the strength of being able to convey a holistic and in depth explanation of a lengthy process whilst keeping an open focus allowing for unexpected effects to manifest and be explored (Yin, 2014). Detailed case-presentations such as Berkowitz' (1998) can be particularly meaningful for clinicians, but a more systematic qualitative method can reduce the risk of bias or 'cherry-picking' in reporting (Yin, 2014).

Additionally, only Campbell et al. (2016) and Morgan and Johnson (1995) included control conditions in their study. In the other reviewed papers it remained unclear whether observed changes were due to AT or rather to spontaneous recovery or expectancy effects (Lambert & Barley, 2001). Lastly, none of the reviewed studies reported a reasonable follow-up period. It is therefore unclear whether art therapy had any lasting impact on participants.

Measures and Analysis

The majority of the reviewed articles failed to present convincing evidence for treatment effects. Case-studies by and large relied upon unmeasured anecdotal evidence rather than on standardised tools. Only Hass-Cohen et al. (2014) used outcome tools and interpreted changes in a meaningful way by referring to the clinical cut-off. A comparison of the achieved shift in scores to the measures' reliable change index would have made for even more robust evidence. In doing so, the reader would have been able to ascertain whether any changes went beyond the measurement error of psychometrics. Moreover, where authors decided against

standardised tools it would have been prudent to use formal qualitative methodology such as thematic or interpretative phenomenological analysis to structure their findings and reduce biases.

Additionally, two out of three mixed methods studies (Allen & Wozniak, 2011; Mims, 2015) omitted to elaborate on the rationale for using both quantitative and qualitative analyses. They also failed to integrate the results from both elements of their study. This has been highlighted as a major factor for quality in mixed methods designs (Pluye et al., 2009).

Researcher Biases

In all studies the author(s) of the papers were part of the intervention. Confirmation bias and researcher allegiance effects are therefore important limitations that must be considered. This is particularly crucial in light of the predominance of anecdotal evidence as opposed to objective measures. Qualitative methodology generally invites the researcher to consider their impact upon the results. It was unclear whether the authors of qualitative studies (Allen & Wozniak, 2011; Lobban, 2012; Mims, 2015) heeded this advice. Their omission to report on researcher reflexivity gave the impression that they failed to consider how their own attitudes and assumptions impacted on the themes identified in the data and on the responses given by their clients.

Sample Size

Sample sizes of most qualitative and mixed methods studies were small. Mims (2015) had the smallest sample size with two interviewees. Unsurprisingly, no change in outcomes was found due to lack of statistical power. Lobban (2012) did slightly better with five veterans. Eleven interviewees can be considered a good sample size for the qualitative element of Allen and Wozniak's (2011) study. One might argue that the quantitative component could have benefitted from more participants but paired t-tests yielded significant results nonetheless. Johnson et al. (1997) recruited relatively few participants particularly considering the

complexity of analyses using factorial ANOVA. The largest study was Gantt and Tinnin's (2007) with $n=72$. Unfortunately, akin to Johnson et al. (1997) the researchers omitted a power calculation as well as effect sizes. However, it must be noted that Gantt and Tinnin (2007) reported the proportions of participants who were recovered as defined by the outcomes measures used. This was a good indicator for clinically meaningful treatment effects as opposed to observed statistical change which is heavily influenced by sample size.

Treatment Received

Issues around generalisability also resulted from the treatment offered to study participants. In most reviewed papers service-users received a treatment package with a variety of interventions along with AT. Only Merriam (1998), Hass-Cohen et al. (2014), Avarahami (2005), and Fitzpatrick (2002) offered AT only. Additional interventions received were psycho-education (Allen & Wozniak, 2011; Gantt & Tinnin, 2007; Lobban, 2012), medication (Berkowitz, 1990; Lamont, 2009), mindfulness/meditation (Allen & Wozniak, 2011; Johnson et al., 1997), individual CBT (Lobban, 2012), Gestalt therapy, NET (Gantt & Tinnin, 2007), and vocational interventions (Johnson et al., 1997). Some papers failed to specify what mental health support their participants received other than AT as part of their treatment package (Berkowitz, 1990; Campbell et al., 2016; Mims, 2015; Morgan & Johnson, 1995; Lamont et al., 2009). Any reported change can therefore not be easily attributed to art therapy. Even Johnson and colleagues' (1997) attempt to evaluate their treatment components separately was not unproblematic. Interventions were offered throughout the day and in quick succession. It is possible that individual effects materialised with a delay thus impacting on the observed changes following another intervention.

The majority of reviewed papers omitted reference to theory or evidence in describing their AT intervention (Allen & Wozniak, 2011; Berkowitz, 1990; Fitzpatrick, 2002; Gantt & Tinnin, 2007; Johnson et al., 1997; Lamont et al., 2015; Mims, 2015; Merriam, 1998; Morgan

& Johnson, 1995). It is possible that those authors used a theoretical basis for their work but failed to report on it. Generalisability and reliability could have been improved in doing so. Only four papers offered clear reference to their underlying theoretical orientation. Three of those used neuropsychological findings (i.e., brain regions associated with declarative and sensory-based memories) to support their approach (Campbell et al., 2016; Hass-Cohen et al., 2014; Lobban, 2012); and two referred to psychodynamic concepts (e.g., artwork as an expression of the unconscious, artwork as a container for strong feelings) (Avrahami, 2005; Lobban, 2012).

Depending on the underlying model, the AT session may differ considerably as well as the types of interpretations offered by the art therapist. As such, findings cannot be easily generalised or transferred to other contexts. Some authors did well in describing their intervention clearly enough for it to be reproducible (Avrahami, 2005; Campbell et al., 2016; Fitzpatrick, 2002; Hass-Cohen et al., 2014; Lamont et al., 2009; Lobban, 2012; Mims, 2015; Morgan & Johnson, 1995). However, others failed to do so (Allen & Wozniak, 2011; Berkowitz, 1990; Gannt & Tinnin, 2007; Johnson et al., 1997; Merriam, 1998; Schouten et al., 2015). Please refer to Appendix A for illustrative examples.

Discussion

Synthesis

In light of the methodological critique presented it was difficult to draw clear conclusions and to answer the research question. The reviewed literature suggested that at least some might benefit from art therapy by reducing PTSD symptoms (Allen & Wozniak, 2011; Campbell et al., 2016; Gannt & Tinnin, 2007; Hass-Cohen et al., 2014; Johnson et al., 1997; Schouten et al., 2015), particularly avoidance, aiding trauma memory processing (Campbell et al., 2016; Lobban, 2012), fostering a more holistic view of self (Allen & Wozniak, 2011; Mims, 2015), and enhancing general well-being (Lobban, 2012). The current review suggests that treatment effects may be greatest for those with the most severe difficulties (Johnson et al., 1997). Anecdotal evidence presented by Avrahami (2005), Berkowitz (1990), Fitzpatrick (2002), Lamont et al. (2009), and Merriam (1998) may inform further research endeavours.

The sceptical reader might argue that due to methodological flaws no conclusions can be drawn. Whilst there are doubts about the validity of findings, themes identified across more and less rigorously designed studies suggest their legitimacy. Those who remain sceptical shall be invited to note that if nothing else, the reviewed literature highlighted the currently existing gap between art therapy practice and its evidence-base.

Research Implications

Critiquing the identified literature highlighted a number of potential avenues for future research. Firstly, proposed treatment effects of AT for people with PTSD presented above should be investigated in a more rigorous way. Methodological robustness could be achieved by increasing the number of participants, clearly defining treatment success at the beginning of interventions, use of standardised psychometric tools corresponding to *a priori* defined treatment success, and administration of such tools pre- and post-therapy. Where small scale research is necessary, researches should use RCI as a comparison to ensure change above and

beyond measurement errors. Ultimately, it would be helpful to aim for the design of RCTs exploring the effectiveness and efficacy of AT compared to a control condition. Moreover, studies should include a reasonable follow-up period to rule out any transient treatment effects.

Secondly, papers presented were exclusively naturalistic. This indicated that art therapy is by and large offered as part of treatment programmes also using other interventions. It would therefore be helpful to attempt to disentangle the effects of each element in the system. This could be achieved by careful selection of outcome measures corresponding to the targets of the individual treatment elements as well as delivery of therapy elements in different stages. Doing so could help to maximise the effectiveness of each component and treatment programmes as a whole.

Finally, it would be helpful to explore the active ingredients of art therapy. In recent years and possibly in response to similar outcomes of different treatment modalities (Wampold, 2001; Roth & Fonagy, 2013) there has been a call for an exploration of the commonalities between psychotherapies (Bateman, 2000). Exploring the mechanisms of change may enhance the effectiveness of treatments and may enable clinicians to truly integrate treatment models in a meaningful and beneficial way. An important path to pursue in art therapy research may therefore be the exploration of ‘how it works’. This is often best begun with qualitative research (Willig, 2001). However, in light of the lack of systematic methodology in such research so far, the need for more robust projects remains. Grounded theory might be a helpful way of exploring how art therapy’s processes might be helpful to service-users.

Clinical Implications

Due to methodological flaws implications for clinical practice are limited. Research presented suggests that art therapy may be a helpful adjunct to treatment of PTSD particularly for the most distressed. It appeared that AT helped to overcome prevalent avoidance of trauma memories. Once avoidance is lifted trauma survivors may be better able to engage in evidence-

based talking therapies such as TF-CBT, NET, CPT, or EMDR. Moreover, research suggested that AT may aid the recovery and/or elaboration of trauma memories. This may be a necessary initial step in order for trauma work using other modalities to be facilitated.

Feelings of shame and/or guilt are common in survivors of trauma (Hendin & Hass, 1991; Herman, 1992). Such adverse emotional experiences might be a barrier to engaging in talking therapies. Art therapy has a clear advantage in that respect as service-users are not required to explicitly talk about their traumatic experiences. Instead they are asked to produce a piece of art that is more or less loosely related to the events and then to talk about artwork rather than the trauma itself. This has been suggested to create a certain (and helpful) distance (Berkowitz, 1990) thus containing strong feelings (Avrahami, 2005) and to allow for gentle and safe trauma-work (Allen & Wozniak, 2011; Avrahami, 2005; Berkowitz, 1990; Campbell et al., 2016; Lobban, 2012; Merriam, 1998). Survivors of trauma who may be less able to benefit from therapies that require recounting of traumatic experiences due to associated shame and/or guilt, may find the gentler approach of art therapy more tolerable and ultimately more beneficial. This might underlie the finding that treatment effects were greater in those with a higher level of difficulties.

Closing Remarks

The current systematic review of research on the effectiveness of art therapy in the treatment of adult posttraumatic-stress disorder suggested that some can benefit from the treatment. It appeared that AT can impact on various symptom clusters of PTSD. The discussed methodological flaws in the design of to-date published papers highlighted a need for more robust research. Further research is needed to establish whether less convincing findings discussed here can be replicated in more rigorously designed projects.

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Gabriel Schnitzer, BSc MSc

Section B

“My Heart on This Bit of Paper”:

A Grounded Theory of The Mechanisms of Change in Art Therapy
for Military Veterans

ACCURATE WORD COUNT:

8000 (474)

(excl. title page, preface, abstract, running heads and footers, figures, tables, reference list)

Preface

Your daddy ain't left the house again. Your dad ain't brushed his teeth.

Your dad keeps getting angry and at nights he doesn't sleep.

He's been having nightmares and he seems worn out and weak,

And yes, I tried to be there for him but we barely even speak.

It's like he don't know what to say to me.

He don't know how to tell it.

He's won medals for his bravery,

But he just wants to forget it.

He's drinking more than ever. I can hear him cry,

When I wake up in the night and I feel him shaking at my side.

But he spoke to me at last, my son. He turned to me in tears.

And I put my face real close to his and I asked him what he fears.

He said: "It keeps getting nearer.

It hasn't disappeared."

He says: "I see it even clearer

now that sand and smoke has cleared."

- Kate Tempest, *Ballad of a Hero* (2014) [excerpt]

Abstract

Background: Posttraumatic-stress disorder (PTSD) is common in military veterans. Research has shown reduced effectiveness of commonly offered treatments in those with military backgrounds. Some research has suggested the usefulness of art therapy for veterans with PTSD. The project aimed to establish firstly participants' perceptions of any impact of group art therapy for veterans and secondly some of the perceived mechanisms of change.

Methodology: Semi-structured interviews were conducted with nine veterans who had received group art therapy, two art therapists, and a veteran's wife. Interviews were analysed using grounded theory.

Results: Theorised categories pertaining to active ingredients of art therapy and its impact included (a) the art therapy group, (b) the art therapist, (c) trust, (d) doing the work, (e) a communication tool, (f) points of recognition, (g) making things concrete, and (h) not a cure.

Discussion: The developed grounded theory is linked with existing literature. Limitations of the study design and analysis are discussed. Clinical recommendation include a call for greater co-operation between psychological and art therapists. Due to the fairly homogenous sample it is suggested to replicate the project at different sites. Elements of the model may be investigated further to establish its validity.

Keywords: art therapy, military veterans, PTSD, mechanisms of change, grounded theory

Introduction

Depictions of warfare have an extensive history. Scenes of battles between tribes can be found in cave drawings dating back 10000 years (Otterbein, 2004; Taçon & Chippindale, 2008). Visiting any art museum today, it would be difficult to avoid paintings of war. This may not come as a surprise considering that remembrance and mourning is the second stage of three in Herman's model of trauma recovery (1992). Illustrations of armed conflicts may aid this process and help to restore the mental health of survivors of war (Lobban, 2018b). The deliberate use of art-making as a form of psychotherapy on the other hand is a comparatively new undertaking.

Military Posttraumatic-stress Disorder (PTSD) and its Treatment

Prevalence rates of PTSD were estimated to be 6.9% in UK combatants (Fear et al., 2010). In comparison with soldiers who did not experience trauma during deployment, those who did were at higher risk of also exhibiting other mental, physical, relationship, and occupational difficulties as well as reduced quality of life (Erbes, Meis, Polusny, & Compton, 2011; Fear et al., 2007; Iversen et al., 2009; Magruder et al., 2004; Shea, Vujanovic, Mansfield, Sevin, & Liu, 2010). McCaslin, Turchik, & Hatzfeld (2015) suggested that military trauma reactions are more complex than single incident traumas. A causal link between stress experienced during military service and mental health difficulties following discharge was proposed in the literature (Dickstein, Suvak, Litz, & Adler, 2010; Jones et al. 2000; Hoge et al. 2004; Browne et al. 2007). Some have also suggested that predisposing vulnerability factors such as parental mental health difficulties and early adverse experiences may be more common in US American and UK service-members compared to civilians (Kessler et al., 2014; Goodwin et al., 2015). Those factors in turn were shown to be risk factors for developing PTSD following traumatic events (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003). Finally, service-men appear to struggle to seek help (Iversen et al., 2010; Murphy, Hunt, Luzon,

& Greenberg, 2014). Murphy et al. (2015) found an average delay between leaving the military and seeking help of 14.6 years. This may be due to a higher frequency of delayed onset PTSD in veteran populations (Smid et al., 2009). Additionally, psycho-social barriers to seeking help may be at play which have been summarised by Murphy and Busuttil (2014). To the best of the author's knowledge, there are currently no studies or reviews comparing military and non-military PTSD directly.

Trauma-focused cognitive-behavioural therapy (CBT) or eye movement desensitisation and reprocessing therapy are recommended treatments (NICE, 2005). Research has indicated that veterans benefitted less from psychotherapy compared to non-military service-users (Watts et al., 2013) and meta-analyses yielded smaller effect sizes in veteran populations (Bradley, Greene, Russ, Duta, & Westen, 2005; Goodson et al., 2011).

Several authors hypothesised reasons for reduced effectiveness of interventions. Pietrzak et al. (2011), for instance, emphasised the repetitive, intensive, and interpersonal nature of combat-related traumatic events. Moreover, symptom severity was shown to be higher in veterans (Brewin, Andrews, & Valentine, 2000) and other diagnoses were more frequent (Forbes et al., 2008). Additionally, UK service personnel appear to struggle to seek help (Murphy, Hunt, Luzon, & Greenberg, 2014). Difficulties are therefore likely to become chronic and more difficult to treat. Haagen, Smid, Knipscheer, and Kleber (2015) conducted a methodologically robust meta-regression of 57 psychotherapy studies with military personnel. It appeared that relatively low or high PTSD symptoms pre-treatment predicted smaller treatment gains compared to medium severity.

Art Therapy: A Viable Alternative?

Despite meta-analytically supported treatment effectiveness of standard psychotherapy (e.g., Cusack et al., 2016; McPherson, 2012; Watts et al., 2013) it must be considered that up to 30% of service-users remain unresponsive to evidence-based treatments (Wisco, Marx, &

Keane, 2012). Furthermore, drop-out rates as high as 36% for commonly used PTSD psychotherapies have been reported (Goetter et al., 2015), suggesting that some could not benefit from or were not satisfied with the treatment received. Finally, re-traumatising the survivors is a risk which must not be underestimated (Foa et al., 2002; Hackman, Ehlers, Speckens, & Clark, 2004). These limitations in combination with above discussed reduced treatment effects of standard psychotherapies in military populations makes the exploration of alternative and bespoke treatment options imperative.

Originally rooted in the rehabilitation of war veterans, art therapy (AT) has since spread into a variety of contexts (Lobban, 2018a; Scope, Uttley, & Sutton, 2017). Over recent years some evidence has emerged for the effectiveness of AT in treating military PTSD. Morgan and Johnson (1995) reported two case studies and found a reduction in frequency and intensity of nightmares in their drawing condition but not in their writing condition. A strength of this case-study was the use quantitative data and statistical analysis rather than anecdotal evidence which dominates the field. Unfortunately, some analyses were underpowered and did not yield significant results. Johnson, Lubin, James, and Hale (1997) reported that AT was the most effective treatment component for veterans with the most severe PTSD symptoms out of a pool of 15 interventions within a specialised residential programme. Unfortunately, their statistical model was too complex to allow for a direct comparison of treatment effects. Instead treatment categories were created and compared. A major limitation of the study was that authors failed to specify which intervention fell into which category. Campbell, Decker, Kruk, and Deaver (2016) conducted a randomised controlled trial investigating whether a combination of AT and cognitive processing therapy (CPT) yielded better treatment results than CPT on its own in a sample of veterans. Both groups improved in terms of posttraumatic-stress and depression. However, no between-group differences were found possibly due to small sample sizes ($n=15$). Between-group differences in terms of depression came close to the significance level with a

small effect size. This might suggest that the difference between control and experimental conditions would have been statistically significant in a larger sample. Lobban (2012) found the themes of ‘connectedness’, ‘opening up’, and ‘processing material’ amongst others in her thematic analysis of a focus group on processes during art therapy. These observed changes were, however, difficult to attribute to AT as focus group members also received psycho-education and individual CBT. Lobban, furthermore, omitted to explore researcher reflexivity. Considering that she was both the focus group facilitator and art therapist, this was an important caveat.

Overall it can be argued that rigorously designed research into the impact of art therapy upon adult survivors of trauma generally, and veterans specifically, is scarce (Schnitzer, Holtum, & Huet, in preparation). Issues with this particular field of study pertained to a predominance of case-study designs, limited use of validated outcome tools, small sample sizes, and researcher allegiance effects.

Dominant Theories of PTSD and Their Links to Art Therapy

In terms of theories that may be particularly pertinent for art therapy with veterans, Litz et al. (2009) argued that moral injuries (i.e., reactions to transgressions of deeply held moral beliefs) associated with guilt or shame were particularly prevalent in military PTSD. Moral injuries may inhibit communication (Keltner & Harker, 1998) and may therefore complicate standard talking therapies. Art therapy may offer a gentler way to explore and ultimately challenge strong feelings of guilt/shame through the provision of a ‘container’ (i.e., artwork) for those feelings (Avrahami, 2005). Alternative and more helpful meanings may subsequently be found through an invitation to look at what had occurred from different angles and by bringing in a future/coping/compassion-oriented perspective (Lobban, 2018b). This may link to psychodynamic theories around the centrality of meaning of events to the survivor (Nijdam & Wittmann, 2015).

According to Brewin and colleagues' dual-representation theory (1996) day-to-day memories and traumatic memories are processed via separate neurological pathways. Trauma memories are visually/emotionally encoded and unintentionally triggered by cues whereas ordinary memories are placed in the context of the whole life story, declarative, and encoded verbally. Research has shown that the hippocampus, part of the limbic system involved in declarative memory, can shrink by up to 26% in military PTSD (Gurvits et al., 1996). By engaging non-verbal and verbal parts of the brain hippocampal activity may be restored and integration of declarative and non-declarative memory systems fostered (Avrahami, 2005; Gantt & Tinnin, 2009; Lusebrink, 2004; Talwar, 2007).

Smith (2016) used a systematic review methodology to summarise hypothesised mechanisms of change in AT for veterans. She identified six themes across the reviewed literature: 1) group processes, 2) externalising image, 3) from verbal to non-verbal, 4) integration and processing of trauma, 5) containment, and 6) artistic pleasure and mastery.

Research Questions

The cited findings suggest that at least some veterans can benefit from art therapy for PTSD. In addition, a number of hypotheses based on established psychological theories regarding potential active ingredients of art therapy have been postulated. However, to-date those hypotheses have by and large not been scientifically tested. Most theories have furthermore not arisen directly from veterans' experiences of art therapy. The current study therefore aimed to explore two questions. Firstly, it was of interest how veterans experienced art therapy and whether any beneficial effects were noted. Secondly, it was to be investigated how the components of art therapy and their interplay facilitate change from the perspective of recipients and facilitators of art therapy. Ultimately, the aim was to develop a model regarding the mechanisms of change in art therapy for combat-related PTSD, grounded in veterans'

experience. A grounded theory model might suggest a more coherent set of hypotheses for testing in future research.

Epistemological Stance

The current project was underpinned by a critical realist position. It is argued that the objective and measurable world is mediated and distorted through a social, cultural, and historical lens. As such, the 'real world' is only partially accessible via the scientific method (Eatough, 2012).

Methodology

Service Context

Participants were recruited from Combat Stress⁵, a mental health charity for veterans that has been commissioned by the Department of Health to provide a national specialist service for veterans with PTSD (Murphy et al., 2015). The charity operates three treatment centres. Treatment is offered as either a two-week or six-week residential programme with weekly art therapy as an integral part. In addition, veterans receive a mixture of individual trauma-focussed CBT and group CBT. During the recruitment period, a new two-week art therapy only admission was trialled. As part of the programme veterans received daily art therapy. Ex-servicemen also completed an AT session with US American veterans via video-link and visited art galleries.

Service-User Involvement

The author observed a focus group at the end of the first two-week art therapy trial admission run by the author's secondary supervisor. Its aim was to gauge the veterans experience and any potential therapeutic gains from the admission. The author had the opportunity to ask questions about veterans' experience of art therapy. Focus group members attested that they had an interest in contributing to research into the mechanisms of change in AT. Moreover, they felt able to comment on active ingredients based on their own experiences.

Research Design

To answer the research questions semi-structured interviews were conducted using open-ended questions (Appendix B). The aim was for breadth and depth of data through

⁵ The charity's research lead has agreed for the charity to be named in this thesis and any publication.

allowing participants to respond freely within the framework of the research questions. Questions were trialled with the first two participants. Both confirmed that the questions were accessible, relevant, and not anxiety-inducing.

Ethical Considerations

The project was approved by the Salomons Ethics Panel (Appendix C) and the ethics panel of Combat Stress. British Psychological Society codes of Human Research Ethics (2010) and Ethics and Conduct (2009) were considered at all stages. A main ethical concern was the possibility of re-traumatisation of participants during the interview. It was therefore paramount to ensure by design of the interview schedule and briefing of interviewees that traumatic events or details of their deployment would not be part of the conversation. As the possibility could not be ruled out, support was made available by Combat Stress if needed.

Participants and Recruitment

To limit the confounding impact of other therapeutic interventions it was aimed to recruit from the AT only programme in the first instance. Overall 15 veterans participated in three groups over the course of 1.5 years. Each participant was approached and nine initially agreed to be interviewed with one dropping out at a later stage. Eight veterans were interviewed on the final day of their admission.

The principle of theoretical sampling (Corbin & Strauss, 2015) was upheld. Data was collected, coded, and analysed concurrently where possible. In the process, hypotheses that might contribute to the final grounded theory were identified and pursued (Birks & Mills, 2011). In line with theoretical sampling, the semi-structured interview schedule was altered according to perceived gaps in the data. Moreover, the number of participants had not been pre-defined. Based on initial interviews a more heterogeneous sample was sought approaching participants in the ordinary treatment packages at a later stage. In addition, some veterans were contacted after they had been discharged for at least eight weeks in a further attempt to clarify

elements of the emerging theory. Of 11 contacted veterans from two centres one agreed to take part. The primary researcher was not part of the selection process for confidentiality reasons. Finally, it was decided to contact spouses for triangulation contrary to initial plans to only interview veterans and art therapists⁶.

All participants were handed the appropriate information sheets (Appendix D). Informed consent forms were subsequently signed (Appendix E). Most interviews were conducted at one of the treatment centres. Some participants were interviewed via an online video-link or at the British Association of Art Therapists' headquarters for accessibility reasons. Interviews ranged from 46 to 78 minutes with an average length of 59 minutes. All interviews were audio-recorded and transcribed verbatim. The first two and the last three interviews were transcribed by the author, the remainder by a professional transcriber who provided written assurance of confidentiality.

Data Analysis

Corbin and Strauss' (2015) approach to grounded theory was used as it sits best with the critical realist stance obtained. Following their recommendations, proposed guidelines were not used rigidly. Instead emphasis was placed on remaining flexible and responsive to the data. Fundamental strategies of (a) making comparisons and (b) asking questions were kept in mind during analysis.

Interview transcripts one to five were coded line-by-line using NVivo (2012). This method produced a wealth of data and reduced the likelihood of overlooking aspects

⁶ An amendment was sought from and approved by the Salomons Ethics Panel on 19.06.2017

respondents attempted to convey (Corbin & Strauss, 2015). In-vivo codes were used predominantly to limit the likelihood of super-imposing meaning onto the data.

Line-by-line coding of the first five interviews yielded a myriad of code clusters. Constant comparison of codes as well as alternating between looking at codes and raw data resulted in 73 clusters that appeared to describe similar concepts and processes. Provisional titles of clusters can be found in Appendix G. Excerpts from the subsequent interviews were then assigned to those clusters and focus-coded using the comment function of Microsoft Office Word 2007. Emphasis was placed on remaining open to quotes being moved between clusters and to new clusters emerging as part of the analytic procedure. Moving further away from purely descriptive coding and analysis, diagramming was introduced (Birks & Mills, 2011). The primary researcher used post-it notes to organise codes. Research diary and memos (Appendix H) were invaluable during advanced coding and subsequent theory integration. The initial list of clusters was thus reduced to 33 clusters (Appendix I) having included two further interviews. Those clusters constituted early and tentative categories with properties and dimensions. Categories are abstract terms that denote the major similarity of groups of codes (Corbin & Strauss, 2015).

Inclusion of the remaining two veterans' interviews resulted in separating the data into six main areas: (1) the group, (2) the art therapist, (3) the session, (4) immediate reactions to the work, (5) art as a method of communication, and (6) longer-term impact of the work. All codes from each of those areas were organised into emerging categories using diagramming and placing particular emphasis on links between them. This procedure yielded 25 tentative (sub-)categories (Appendix J). Those were explored in depth by re-visiting the interview transcripts and comparing the codes within the categories. As part of the final stage it was attempted to raise the analysis to the highest conceptual level and achieve theoretical integration. This occurred in two steps with an earlier version depicted in Appendix K. In line

with Corbin and Strauss' (2015) paradigm, the researcher particularly focussed on (a) conditions/perceived reasons, (b) actions-interactions, and (c) consequences. In doing so, categories were interwoven thus giving the emerging grounded theory explanatory power. As part of regular meetings with supervisors, coding, emerging (sub-)categories, and the final model were discussed and reviewed.

Theoretical Sufficiency

Theoretical sampling was stopped once theoretical sufficiency (Dey, 1999) was achieved. Sufficiency is reached when further data collection is unlikely to add properties or dimensions to established categories. Contrary to Corbin & Strauss' (2015) goal of saturation, theoretical sufficiency does not assume a completeness of collected data. The aim was to reach a point where the grounded theory and categories within it made sense to the researcher (Morse, 2007). Supervision was used to gain a second opinion as to whether or not sufficiency had been achieved.

Quality Assurance

Critical Appraisal Skills Programme's framework for evaluating the quality of qualitative research (CASP, 2013) was used as a quality check at all stages of the research process. To ensure quality more specifically regarding grounded theory the factors for quality assurance recommended by Birks and Mills (2011) were held in mind. Table 1 provides a more detailed description of how those criteria were attempted to be met.

Table 1.

Ways in which quality was attempted to be assured based on Birks and Mills (2011) grounded theory quality criteria

<u>Quality criteria</u>	<u>Strategies adopted</u>
Researcher expertise	<ul style="list-style-type: none"> • use of transferrable skills learned through previous quantitative and qualitative research projects • primary researcher's supervisor's previous experience in conducting and supervising grounded theory projects • close study of seminal grounded theory texts (i.e., Birks & Mills, 2011; Charmanz, 2006; Corbin & Strauss, 2015; Dey, 1999) • close study of published grounded theory research (e.g., Camic, 2010) • participation in peer supervision group alongside other doctoral candidates using grounded theory
Methodological congruence (i.e., concordance between epistemological stance, aim of research, and the methodology)	<ul style="list-style-type: none"> • to the best of the primary researcher's knowledge the stated aims were in accordance with the critical realist stance adopted • Corbin & Strauss' (2015) approach to grounded theory fits well with aims and the underlying epistemological stance.
Procedural precision	<ul style="list-style-type: none"> • described analytic strategy may assure the reader of adherence to rigorous research methods • research diary and memos to aid theory development and to maintain an audit trail • collected data kept on a password protected and encrypted memory stick and stored at the researcher's university for five years. • documents and files used for coding kept for review upon request • analytic strategy alongside appended earlier stages of the final model may demonstrate procedural logic • respondent validation: all veterans sent a synopsis of model (Appendix L) and encouraged to comment and highlight perceived errors/gaps → all felt that model fitted their experience of art therapy • researcher reflexivity: preconceptions were likely to have impacted on coding and theoretical integration; influence was attempted to be minimised by line-by-line coding of the initial 5 interviews, use of in-vivo codes, memos/research diary, supervision, and respondent validation

Dissemination

The results of the project were fed back to all respondents (Appendix M). The findings were disseminated to the staff at Combat Stress in the form of a presentation on 9th May 2018. A publication in *Journal of Traumatic Stress* is planned and a manuscript will be submitted in due course.

Results

This section will first describe findings from interviews with veterans and will then move on to discuss the results from the triangulation interviews.

Situating the Sample

Table 2 presents veterans' demographics. All of the interviewed veterans were male and identified as White British. Their mean age was 58 years ($SD=9.02$)⁷. Seventy eight per cent had received previous treatment and two thirds had attended art therapy before the current admission. Only one veteran was not on psychotropic medication.

Table 2.
Demographics of interviewed veterans.

Participant alias	Age (in years)	Marital status	Employment	Length of active service (in years)	Previous treatment	Previous AT	Current intervention
Eric	72	married	retired	6	yes	yes	AT only
Joshua	58	married	retired	16	no	no	AT only
Kurt	64	married	retired	6	yes	yes	AT only
Thom	62	married	long-term sick/disabled	7	yes	yes	AT only
Otis	63	married	unemployed	16	yes	yes	AT only
Dave	52	married	retired	23.5	yes	yes	AT only
Alex	43	married	employed	12.5	yes	no	AT only
Robert	52	co-habiting	unemployed	5.5	yes	no	AT only
Chris	-	married	employed	7	yes	no	6-weeks combined

Mechanisms of Change of Art Therapy

The developed model gave insight into processes that based on time and location could be broadly separated into two main phases: the art therapy session and after the session (see Figure 1). The first phase yielded more information regarding the second research questions,

⁷ One participant chose not to disclose his age.

(i.e., the mechanisms of change in art therapy) whereas the second stage offered insights into the impact of art therapy upon veterans with PTSD. Please note that all in-vivo codes are in quotation marks. Please refer to Tables 3-15 for additional quotes illustrating properties, dimensions, and conditions.

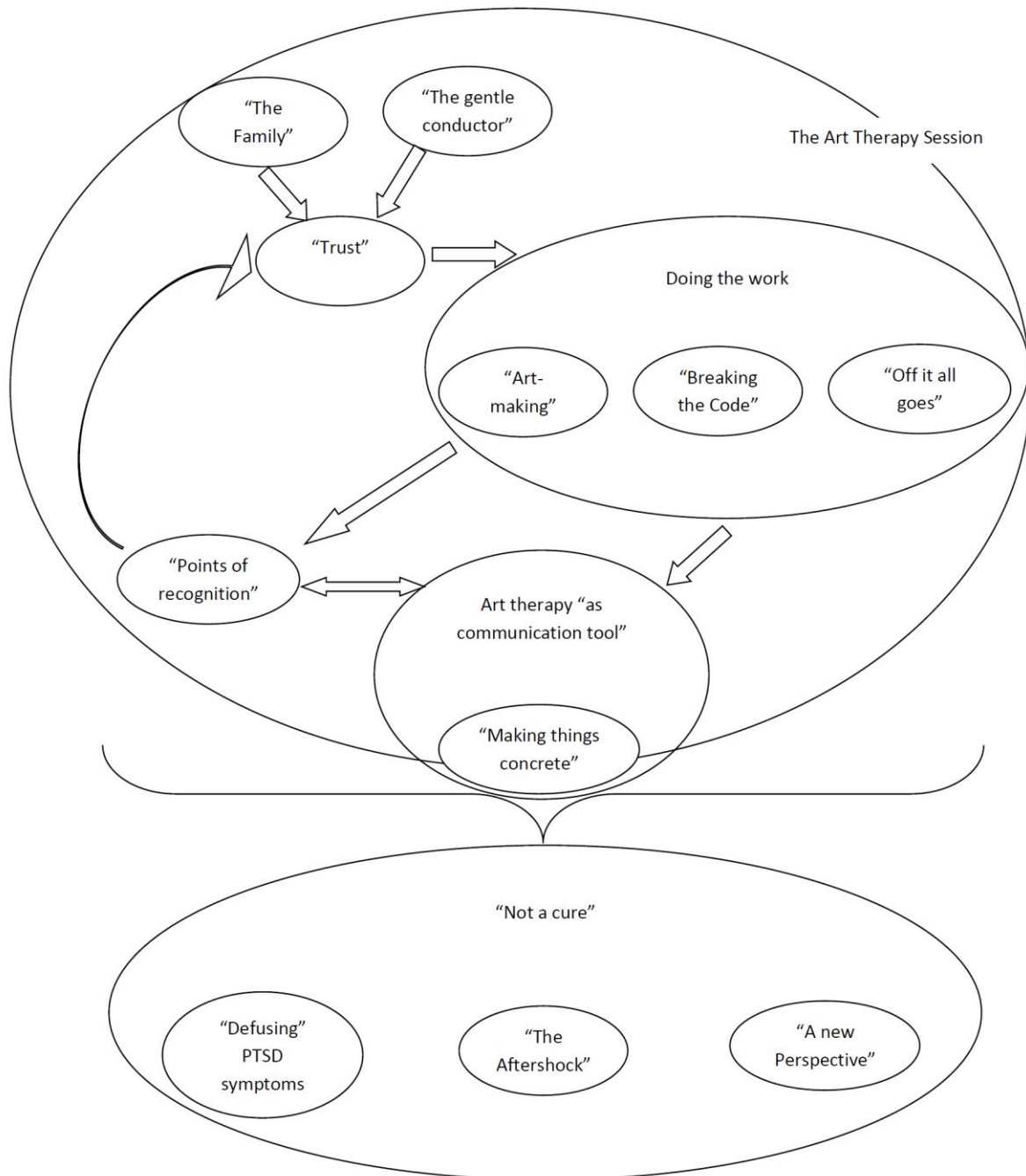


Figure 1. Diagrammatic model of developed grounded theory

Processes During Art Therapy

The Family

Table 3.

Category of “the family” with its properties and quotes.

<u>Properties</u>	<u>Illustrative quote(s)</u>
“Size”	Eric: “And the other, yes, very important not too big. Just, that’s very important. One over the top and it just doesn’t work.”
(Explicit and implicit) “ground rules”	Eric: “And the ground rules are all understood by everybody.” Robert: “Yeah, okay, we have a laugh, but when it comes to that part of it, nobody’s judging you. People listen to what you’ve got to say and even if it’s not relevant to them they do, you know, they take time to listen.
“select group”	Dave: “And because we were here almost hand-picked to do this because we’d responded so well, the group functioned really easily.”
similarities	Kurt: “Well there’s a common bond between people who’ve been in conflicts [...] We’ve got the same symptoms, some of us were in the same conflict, in the same piece of ground, so that creates a common bond [...] And we all seem to be on roughly the same wavelength, and so if you’re on the same wavelength you all kind of mesh together because you all understand each other”
differences	Otis: “From a different angle. Not from a knowledge, right? Because everybody’s different, every trauma’s different. Everybody’s different and everybody’s approach to things is different.”
Supporting each other/ learning from each other	Kurt: “[...] as a group, we sort of all helped each other through it. I don’t know if I could have done it on my own, and I don’t know if I could have had the strength to do it, to go on a one-to-one art therapy without the support of the others first.”

All veterans agreed that the bond to their fellow group members was an essential component of art therapy. According to Otis, for example, “the group’s massive”. A number of metaphors were used to describe the nature and function of the group. For instance, Eric called it “a string quartet”. The description that appeared to fit best with what the group provided was “the family”; an analogy used by both Joshua and Otis. Similar to a well-functioning family, group members offered each other mutual social support and opportunities to learn from each other. “The family” was defined by its size and participants agreed that it

should neither be too small nor too large. Eric found six to be the maximum number of participants but other veterans were less specific. “The family” operated on the basis of “ground rules” some of which were explicit whilst others were implicit. Mutual respect, letting each other talk, an ability to work quietly, and to not talk directly about traumatic events was important to respondents. “The family” was described as “select group” whose members were “on the same wave-length” sharing traits such as a similar sense of humour, being “mature”, and “taciturn”. They also all had a “military background”, the “same problems” (i.e., PTSD), and “a shared goal”. Some differences were acknowledged such as different levels of artistic skills, a different approach to the art-making process, and being at different stages of their journey. The following quote from Otis’ interview illustrates a number of properties of this category well.

I think that this place in particular, if you come here you meet like-minded people, so all your guards are dropped. You don’t feel any threat, you don’t feel guarded, you don’t need to tuck yourself away, in my case, you can just relax because you’ve got like-minded people here and they’ve all got the same problem. No-one hides the fact that they’ve got problems, they don’t tell, I mean you don’t talk trauma but no-one hides anything. And you just feel comfortable amongst ex-servicemen, servicemen, whatever [...] I suppose it’s like going back into the forces a bit, the same humour pops up , you know, all this sort of stuff. So it’s, you feel comfortable, you don’t feel guarded.

The Gentle Conductor

Table 4.

Category of “the gentle conductor” with its properties and quotes.

<u>Property</u>	<u>Illustrative quote</u>
“Calm”	Dave: “They’ve got to be very calming. There’s an aura about Beth that when you very first meet here, you know straight away that everything’s going to be alright. She’s only a dinky little dot anyway, but she’s so calming, relaxed, even when I’ve had my one-to-ones with her. There’s just a really nice, warm, fuzzy feeling.”
“non-judgmental”	Alex: “They weren’t judging us. We were judging them, but the instructors weren’t judging us.”
Being able to “help veterans to open-up”	Joshua: “I think whereas you on all those other therapies where it’s individual and they’re trying to get bits of information out of you, but the more they try the more you fasten your box up. So like I said it took me 10 years to talk to Judith [psychotherapist] about one subject. Over a year and a half with Beth I’ve talked about three subjects.”
“the right balance”	Otis: “So it’s so quiet when you walk into the room and Beth speaks so softly and everything else, she doesn’t take control or anything like that. Chris: “I would say it’s because there’s somebody there, I think you need somebody there to lead that. You need that bit of focus.”
In charge of: a) providing the theme/topic, b) providing the context, c) keeping the structure, d) support in reading the images, e) record keeper	a) Dave: “An easy starting point. Something that Jan’s very good at is picking the topic” b) Eric: “One of the very interesting ones we did last Friday. We had a link-up with an American veterans group in Connecticut.” c) Otis: “It’s just every time we come in she explains what’s going to happen, and it’s basically the same as what happened before, and... you know, but everyone feels comfortable” d) Alex: “Not in the design phase [...] They would make input on the communication phase, on the second part. Just to highlight where you might have not seen you’ve done something yourself.” e) Dave: “And Beth did a thing with us the other day[...] where she laid out all our work, you know, from day one to the last day of all the stuff I’d done.”

The art therapist was another main component of effective AT. Veterans valued their “calm”/“gentle” nature and the “non-judgmental” approach to the work and veterans in general. Respondents felt that their therapist was able to strike “the right balance” between remaining

in control and handing control over to the membership. It was felt that the therapist helped participants to open up. Eric's analogy of a "gentle conductor" seemed to describe this category well. "The gentle conductor" was responsible for providing the theme/topic of the art therapy session (e.g., 'personal quest', 'perceptions', 'resources') and providing the context (i.e., "the ambiance", other activities such as museum visits and video-link to US American veterans). The therapist was in charge of keeping the structure, they may support in interpreting the artwork, and they act as record keepers.

Trust

Table 5.

Category of "trust" with properties and quotes.

<u>Property/condition</u>	<u>Illustrative quote</u>
towards the "gentle conductor"	Eric: "Yes, and that's one of the very important things about the group that's here. They know Beth going back 10, 12 years. So there's a huge amount of trust there, enormous amount. That's really I think what makes this group work so well"
towards "the family"	Kurt: "You have to be in a position where you can trust the people around you. If there's someone disruptive you tend to be very quiet and not want to engage."
time spent together	Joshua: "I suppose Eric I have known for a long time. [other veteran] I have known for a long time. Er, Robert I've met him now and again. And Thom I've never met in my life. So I don't know, just the-the nature of everybody that just jelled."

Both "the family" and "the gentle conductor" appeared to be conditions for the development of "trust". Participants spoke about a deep sense of "trust" towards the other group members. In addition, veterans felt that their trust towards their art therapist was essential for doing the work. Joshua posited that "if you had [...] an instructor or a teacher where you didn't have the trust, it won't work". Aside from the properties of the previous two categories that were seen to be essential to build "trust" (e.g., similarities between group members, adherence to ground rules, calm and non-judgmental but active approach of therapist) there appeared to be a temporal aspect as well. Whilst not seen as a requisite, time spent together seemed to

support the bonding process. Kurt felt that “people with this disorder tend to be reclusive, and trust has to be built”.

Doing the Work

Table 6.

Category of doing the work with its properties and quotes.

<u>Property</u>	<u>Illustrative quote</u>
“active and creative”	Eric: “It’s difficult, it’s very difficult to explain. It’s-it’s one of the, I suppose it’s a, it’s a, it’s a type of creative thing. At the same time it’s personal.”
“here-and-now” focus	Eric: “Erm, and another thing that is important, just occurred to me there, very often the, the work deals with the here and now.”
Combination of “verbal and non-verbal	Thom: “Yeah, because the right brain would be wanting to communicate in these symbols with the left brain once it can communicate in speech. And the art therapy allows the right brain to put this down [...] This is why I find it so powerful, because it puts the two halves of the brain, it gets them speaking in a common language. Instead of one side using words and the other side using symbology, it forces both of them to work in the same medium.”
“set structure”	Kurt: “And it’s usually two phases, the drawing of the thing, and then the explanation of what you, the situation you want to get out.”
“time-limited”	Eric: “[...] the first hour is making the art and doing the actual assignment. And the second hour is actually talking about what one has done.”
“progressive”	Kurt: “I found this the best way of doing it. As opposed to sitting talking to someone about something. And losing my train of thought, getting angry, getting... not wanting to talk. This way is progressive. A beginning, a middle, and the end.”
condition: “that point in the middle”	Joshua: “Whereas if it’s out, slowly, a little bit at a time, you’re able to control that. Well I do anyway [...] So as long as you got that grip on the uncontrollable then it’s easier to talk about it. It’s when it comes out and there is no control over it and you just bubbling and you got no control. So the-the nightmares become more fiercer. And sleep just don’t exist. But as long as you’re in control then it works. It works for me.”

Without “trust” no beneficial work can be completed. Kurt, for example, stated that trust is “100 percent important [...] without the trust you wouldn’t have the confidence to go the extra mile”. Furthermore, operating at “that point in the middle” in terms of control wherein

control is shared between “the family” and the art therapist was seen to be most helpful for effective work. Veterans experienced a sense of control as they were not obliged to speak, use prescribed ways of art-making, or make art at all. The slow pace of the sessions added to the sense of control. A quote from Joshua’s interview encapsulates this:

It all being washed out at once, you’re trying to control what you talk about. And the nightmares start rushing in. So, you got no control. Whereas if it’s out, slowly, a little bit at a time, you’re able to control that.

Doing AT was repeatedly described as an “active” and “creative” type of therapy. It had a clear “here-and-now focus” and combined “verbal and non-verbal” elements. Moreover, the sessions followed “a set structure” that was “progressive” and “time-limited”.

Art-making

Table 7.

Subcategory of art-making with its properties, dimensions, conditions and illustrative quotes.

<u>Property/dimension</u>	<u>Illustrative quotes</u>
“a private affair”	Eric: “You know, art therapy is a private thing. It’s done in a very, a very, er, private sort of, er, [way].”
“therapeutic”	Eric: “The art therapy is an activity in very, in a nice setting. And, erm, activities are useful ‘cos you know when you could, half of it, if you’re doing something and you’re not talking that’s quite therapeutic in itself.”
“Heartfelt doodles” limited by a) “skills level” and b) “time”	a) Eric: “Although I have to confess my own skills are-are probably beneficial that I can start off with a doodle and just develop it into something else.” Otis: “[...] people think they’ve got to be good. And the guys that are on the course know that you don’t have to be good.” b) Alex: “But it was also the staff here giving me the time, giving you 45 minutes to what essentially would be a doodle. You know, you’re not looking at any architectural drawings here, you’re looking at a doodle to explain your mind and what’s going on in your life right now.”
“subject” range: ↑ “positive”/”happy” “deep and dark” ↓ “horrible and nasty”	Chris: On the one session, that I’m looking at now, with the belly-laugh with my wife, I came out of that and that’s all I could remember that happy time.” Alex: “[...] you’re drawing about things that are difficult.” Kurt: “[...] you’re discussing things that happened in the past, using analogies, describing things that were very horrible and nasty.”
“it just happens”	Joshua: “You don’t actually think ‘oh I’ll do this’, you just start drawing I suppose unconsciously and you’re doing this picture and then you realise what you’re drawing.”

Table 7. (continued)

<u>Condition</u>	<u>Illustrative quotes</u>
condition: “horses for courses”	<p>Robert: “I think that’s personal choice. What you’re comfortable with. I started with crayons, pencils, and then I found that with the pastels I was just more comfortable with, then a combination of both. [...] with me it was very what I call ‘rough lines’ rather than using a ruler or anything like that [...] And then to a certain extent I think some people would use cutting pictures out, making a collage sort of thing. I don’t know whether that’s me lazy, not being bothered to look through, or whether it’s just it was easier to do it in the pastels.”</p> <p>Dave: “It’s mood-dependent. Depending what I’m feeling like on the day, depends what I’ll work with. And each one, like if I’m really down it’s generally clay, because then you have that physical, [growling], shaping and moulding and what have you. And through that you can release a lot of tension. Because it’s the physical motion of doing something, interacting with the clay, and by the time you’ve finished there is a tension release and it brings you down. And in lighter moods I’ll use pastels or charcoals. Because you can’t be aggressive, you can’t really shake things up too much because they’re a light material, you have to be more gentle and relaxed. [...] Some days it’s words, some days it’s movement in pictures, of going from one place to another. Or things breaking and moving away. Memories. Looking forwards. This was printed. [...] And it’s dependent on where you are at that time. Because every time you go into a group you’re in a different place or a different position of mental states or emotions.”</p>

The first part of the session is spent on producing artwork. It is based on a theme provided by the “gentle conductor”. The initial stage is “a private affair” and for some it has a “therapeutic” effect in and of itself. Artwork produced was described as “heartfelt doodle” that was limited by the time available on the one hand and artistic skills on the other. A doodle in this context did not necessarily have to be a visual drawing but referred to artwork that is produced ‘on the spot’ also including poems or simple sculptures. This clarification was a result of respondent validation (Appendix N). It is important to note that the quality of the artwork was felt to be irrelevant.

The “subject” of the pieces of art can be described on a continuum ranging from “positive”/“happy” over “deep and dark” to “horrible and nasty”. Whilst a certain level of “artistic skill” was deemed helpful in the art-making process, it was not felt to be essential. The

medium of the artwork was also experienced as important. Otis used the phrase “horses for courses” to describe the choice of material. Others seconded the view that their choice was based on personal preference as well as being able to work quickly. Moreover, the medium was at least for Dave dependent on his state of mind of the day.

Please refer to Figure 2 depicting the use of wide range of materials.



Figure 2. Artwork by Robert pertaining to the theme of ‘objects’.

Interestingly, most veterans reported a certain automatic, effortless, and unplanned process occurring during the art-making phase that was titled “it just happens”. Veterans found it difficult to explain but when engaging with the topic sooner or later something would manifest and they would start to produce their art. Some saw something mysterious or even “magical” in this process. Otis found a powerful way to describe this:

Once you’ve got the subject, in my case I was sitting there for twenty minutes because I go blank, nothing. But I just pick up some paper, various different pens and things [...] and then I just... things just... come to you, you just start doing

things and they appear and they make sense [...] I don't know, I can't explain it. But it's like a magician, you know? It's just something that... I get this image of these fairies... I know it sounds stupid, but in Sleeping Beauty, you know when they do that and all the sparkles come out. There's the little fat fairies dancing around and going "do de le do, de", that's how I felt during this thing.

Breaking the Code

Table 8.

Subcategory of "breaking the code" with its properties, conditions, and quotes.

<u>Property/condition</u>	<u>Illustrative quote</u>
Making sense/ explore "meaning"	Thom: "And some of the symbols, things that you draw down, they have absolutely no meaning when you do them. And you'll come to realise them sometimes when you're in the group discussion afterwards. Often because somebody else tells you, recognises what it means and you don't."
"talk about the picture"	Otis: "That you've opened up and... but you don't actually, you don't talk to, nobody's ever spoken about their traumas or anything like that."
"group effort"	Otis "Well it's a group thing, isn't it. So she [art therapist] wouldn't say "what does that mean to you", the author of the piece or whatever, she would say, put that up on the wall like that and have that one there, only one at a time, and you would then explain what, why you done that, you go through it [...] And then someone will pick up something, they all would, one, two and three. Instead of you sitting there explaining what it was all about, I mean you are given the chance, you do. Then it's gone over to the rest of them and they sort of took it all up, and they started explaining it and saying how alike it was to the one that they were going to show in a minute, and stuff like that.
Condition: "simple and easy to read" artwork	Eric: "And the line drawing is useful because it actually, erm, it's gotta be direct and it's got to be actually, it's got to be, you be able to read it. So I'm not terribly into, I'm not actually getting into art, erm, painterly sort of things. I'm keeping it very simple. And I'm not trying to actually do a Michelangelo version of something like that. So I had to put, er, that's put to one side."

In the second stage of an AT session the artwork is viewed and discussed in the group. It is a phase of "meaning making" and as the meaning is often concealed Kurt's analogy of "breaking the code" appeared to describe this subcategory best. "Breaking the code" is a "group

effort” as members might see different aspects in each other’s artwork. Whilst the art therapist had minimal input during the art-making stage, they might contribute to reading the imagery. It was important for veterans that the aforementioned ground rules were adhered to in that “the family” talked “about the picture” and not about any underlying traumatic experiences. It became clear that art-making is intrinsically linked with “breaking the code”. “Simple and easy to read” artwork made the second stage more manageable.

“Off It All Goes”

Table 9.

Subcategory of “off it all goes” with its properties, dimensions, and quotes.

Property/dimension	Illustrative quote
“bodily reaction”	Otis: “Sometimes your body, ‘cause you get mental sensations in your physical body, heartbeats, sweats, nervousness, all of that. And you can get that as you’re drawing.”
“gets your mind going”	Kurt: “Do we feel in control? It’s a controlled environment, and I feel confident to discuss things with her [art therapist]. But my heart’s beating rapidly, and my mind is going ten to the dozen, and because of the disorder I have I’ve got to try and get things in order to be lucid. Because you have a thousand thoughts all trying to get out at once.”
“all of those emotions” range:	Chris: “You do not realise. You just get carried away with it. I did. I been in a group, it’s been in a session, perhaps sometimes I sit there thinking “what am I gonna do?” [...] And every time I had that sort of light bulb moment, yeah, I know where I’m going with this. And then that was it and all of a sudden she goes “time to finish now!” Like “where did that just go?”
↑ “getting lost in the work”	
“relaxing”/“grounding”	
“surprise”/amazement	
“relief”/“reassurance”	
Saddening/distressing	Robert: “I didn’t find art therapy a task. Once I started doing the drawing I found it quite relaxing.”
↓ “panic”	Eric: “Now that was really something quite, erm, it was quite an amazing experience.”
	Eric: “It’s comforting [...] You know, it’s reassuring.”
	Otis: “[...] he [other veterans] actually let it go to the group and cried in the process. You know, and all four of us have cried at one point or another doing the thing so.”
	Dave: “Sometimes it helps to put things to bed. To sort of close a passage. And then other times it will put me into a panic because I don’t want to remember that, I don’t want that to start impacting on my life again.”

The final subcategory of doing the work pertained to a list of immediate experiences during the session. Those could be categorised into three areas that appeared to be impacting on each other. Firstly, a range of mostly unpleasant “bodily reactions” was described, for example, heart palpitations, sweating, and nervousness. Secondly, doing the work appeared to get veterans’ “minds going”. A cascade of thoughts including both pleasant and unpleasant memories were triggered by engaging with their artwork. Interestingly, Alex describe a striking

“organic development” of drawing and thoughts wherein “as the picture developed, so [his] thoughts developed”.

Finally, the most frequently mentioned area pertained to “all of those emotions”. Every veteran talked about a range of feelings experienced during the AT session. Those were organised along a dimension from pleasant to unpleasant emotional states. On one extreme end of the continuum was “panic” which was only described by Dave. Kurt, Otis, and Alex experienced sadness or distress during the sessions. Some talked about a sense of “relief” or reassurance. All veterans reported numerous moments when they felt “surprised” or even “amazed” as part of their AT sessions. Joshua, Dave, Alex, and Robert found aspects of the session “relaxing” or “grounding”. Otis, Dave, and Chris described flow-like experiences where they became “lost in the work”.

A Communication Tool

Table 10.

Subcategory of “a communication tool” with its properties, conditions, and quotes.

<u>Property/condition</u>	<u>Illustrative quote</u>
“it’s easier to draw than to talk”	Eric: “Erm, it’s a lot easier than talking to somebody and talking about the process of doing it. Erm, certainly for me, it’s a lot easier to produce a drawing.”
“a picture is worth a thousand words”	Chris: “One thing that works for me and perhaps for others is the simplicity of it if that makes sense. It’s not that you have to sit and talk to somebody and explain your experiences and how you’re feeling. You can do that with one image and as I said there’s so much going on behind that image. I find it, especially for people who don’t wish to talk a lot you know. It’s a way of expressing your feelings really quickly.”
language: “symbols”, “analogies”, “metaphors”	Otis: “I like to do things that are, that explain things through art. But not a direct picture of a gun, picture of a battlefield, things like that, I don’t do that. Mine’s more sort of woolly, I think. It’s got a meaning to it, but it’s... until it’s explained, you can’t see it, if you know what I mean.”
content: a) thoughts b) feelings c) situations/difficulties	a) Alex: “So it was nice to come here and put my thoughts into a drawing, a doodle, a sketch, and then talk about that.” b) Chris: “Feelings. Memories. Definitely feelings and memories [...] Feeling of, sometimes a bit of feeling of desperation ‘cause from one image it told you a lot about how’d been feeling and how you’d been for a long time.” c) Kurt: “It was excellent [...] Because you’re able to fully explain the situation you want to talk about through the means of art therapy, through a picture. As opposed to doing it cold, face to face with nothing.”
recipients: a) “the family”, b) “the gentle conductor” c) the self d) others outside the art therapy session	a) Dave: “And I’m not an artist by any means, but once you’re given the subject of the day and the thought process of how to turn that into pictures, somehow brings out of me in the end of group discussions feelings, emotions, and being able to share with others, which I find very difficult normally.” b) Kurt: “As I said, it’s a medium for getting out situations without talking to someone point-blank. And [the art therapist] could read into your pictures, something you might put down into the picture and she can read into it, which you can’t read into it. Because she can kind of decipher a code, if you know what I mean.” c) Eric: “. I think what art therapy is it’s looking, it’s looking for a way to say something. And you don’t know what you actually want to say until you start doing it.” d) Robert: “It’s like they say, a picture speaks a thousand words. To the point of, with my one-to-ones with the therapist, I took a picture in to explain a situation because that was easier than me trying to describe it.”

Table 10.

(continued)

<u>Property/condition</u>	<u>Illustrative quote</u>
“a safe way”	Kurt: “It’s not an instant cure but at least I’ve got it out in the open. And I’ve been able to do it in a way which has not horrified anybody, not frightened anybody. Well I mean, pictures are pretty harmless. I’ve got my message out.”
condition: “feeling safe/comfortable”	Alex: “we were all comfortable with talking to each other and explaining parts of our lives through the drawings, and it was helpful.”

The main benefit that veterans saw resulting from their engagement in AT was the possibility of using art as “a communication tool”. Participants reported that it was generally hard for them to open-up about difficult experiences in their day-to-day lives. Interviewees confirmed that it was “easier to draw than to talk”. They repeatedly stated that “a picture’s worth a thousand words” alluding to their experience of artwork carrying a breadth and depth of meaning. The language of communication were “symbols”, “metaphors”, and “analogies” which can be deciphered as part of “breaking the code”. Figure 3 shows the use of ‘Snakes and Ladders’ as an analogy for Robert’s current life situation.

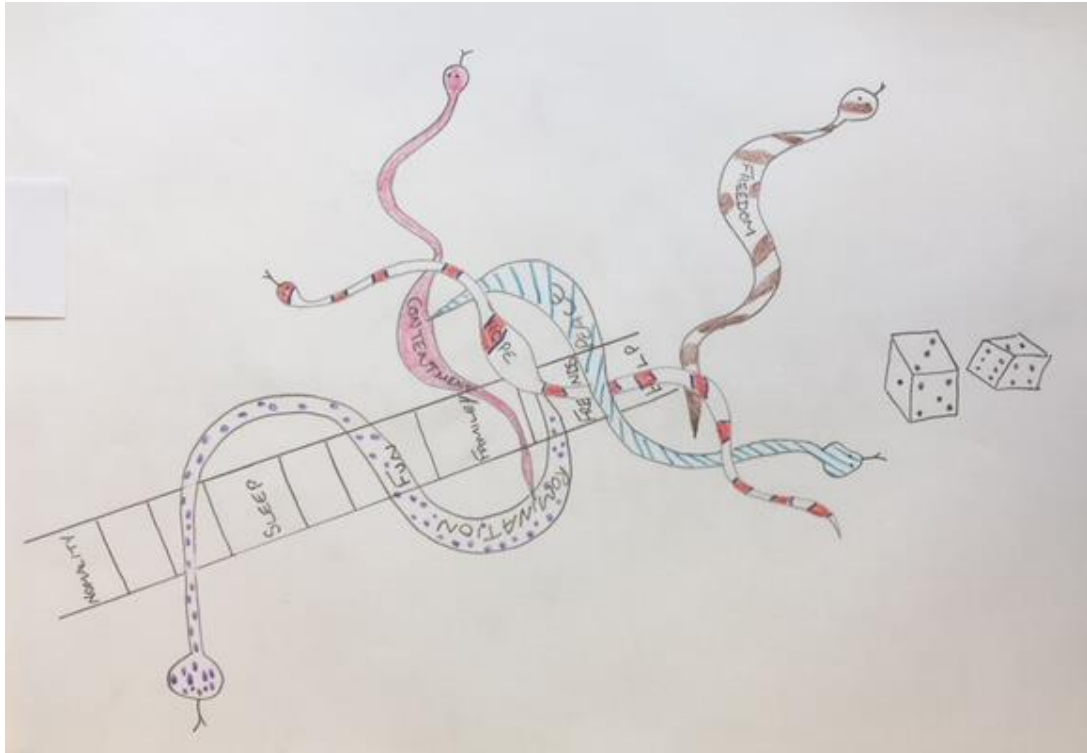


Figure 3. Artwork by Robert pertaining to the theme of ‘road to recovery’.

The content of the communication can be thoughts, feelings, or situations/difficulties. Recipients were “the family”, “the gentle conductor”, others outside the art therapy situation, and the self. For instance, Eric explained: “I don’t know what I think until I see what I draw.” Importantly, using artwork to communicate offers “a safe way” to touch upon harrowing experiences. Participants felt that “feeling safe/comfortable” was necessary to use art therapy as a communication tool. “Feeling safe” appeared to be an amalgamation of “trust” and experiencing a sense of control.

The following quote illustrates powerfully several described mechanisms. Please also see Figure 4; the drawing that Alex referred to.

So I've always worked in intelligence and I would never talk about that [...] That's secret, that's me, it's not to do with anyone else. But I found here, I drew one particular picture that showed me, a picture of me with many different shadows coming from my feet. And that's how it felt and I was able to explain that I can't

find the right shadow because I've been in the shadows for so long, and hiding for so long. And that's difficult to tell someone. [The painting] helped explain where I normally wouldn't say to people, [...] But that allowed me the opportunity to say 'I've worked in the shadows and now I find it difficult to work out which shadow's real. Which one is me.'

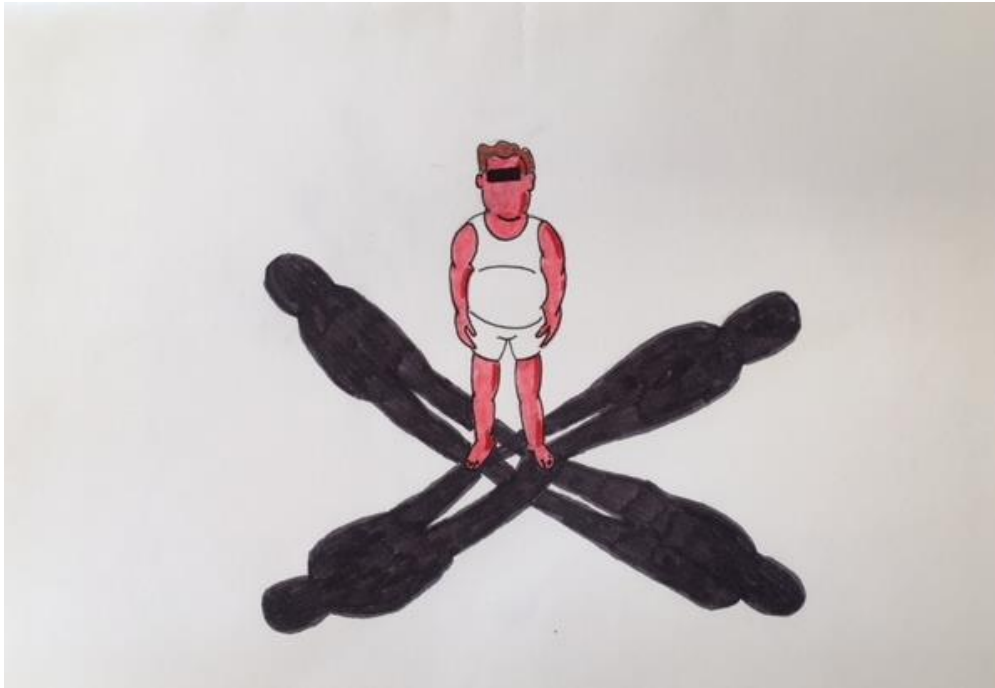


Figure 4. Artwork by Otis pertaining to the theme of 'identity'.

Points of Recognition

Table 11.

Category of “points of recognition with its properties and quotes.

<u>Property</u>	<u>Illustrative quote</u>
Similarities between artwork of different group members	Otis: “So no two things are alike, and when they start talking about their artwork up there on the wall or whatever that they’ve done, they sit there and just sort of explain it. And when they explain it you’re thinking, you notice things in your own, you know? And you notice things in his. [...] They’re all similar, every one of them. They’re not dissimilar. But they’ve all come from different routes to it.”
Similarities between artworks of one group member across time	Thom: “And that didn’t, that symbol didn’t mean anything to me for about six years. And that was when this other dragon started to come out, this Taffy, he became a major character. And he was the symbol of, as I said, my self [inaudible] inside. But he had actually, it was amazing to see, when I look back through the pictures I’d done because Beth, the therapist, she keeps them all on file. We were looking back through one day, back what I’d done, and I said ‘good God, I’ve drawn it there!’”

All veterans shared that frequently there appeared “points of recognition” in the work. Those could be between works of art of different group members or within one participant across time. Similarities can include symbols used, a general feeling/situation communicated in the artwork, as well as explanations given when “breaking the code”. Those “points of recognition” had a profound impact on veterans both during the session and after. Reactions were coded as part of “off it all goes” as well as under “a new perspective” and “the aftershock” below. Some argued that “points of recognition” strengthened existing “trust” further.

Making Things Concrete

Table 12.

Subcategory of “making things concrete” with its properties and quotes.

<u>Property</u>	<u>Illustrative quote</u>
“can’t be changed”	Dave: “Because you can say something and then think about what you said, and without realising it you change words that you physically said to words that you think you’ve said. But when you’ve drawn it or painted it or modelled it or whatever, there is no changing it. It’s there. And you can look at it from different angles and perspectives but that picture will never change. But your explanation about that picture can.”
“a record of the journey”	Chris: “Of your journey! Yeah, yeah, definitely. Er, which is why I wish to, you know, and I don’t think there’s many in my, and I know different people do different things but I think I was the only one in my group that I took all the imagery home with me. For that reason because I find it is good to look back on them.”
Can be revisited	Dave: “your drawing, hours later, a couple of days later you can go back to it and think of it in possibly a better light, or ‘oh, now that really does make sense to me, why I drew that’. Or ‘really, what was I thinking about? Why was I like that?’. So you get that chance to revisit and possibly have the emotions again, or to move on.”
Can be used after the session	Thom: “This time, I’m glad to say the cognitive therapist was actually extremely good and versatile in his thinking when I told him. Because I explained my problem by taking in some of the pictures that I had, to show this problem of the dissociation and what’s been happening. And he decided that as I seemed to be able to express myself well in pictures, he thought we’d have a go at using art to express the ideas and then deal with the pictures using the cognitive principles.”

Once the artwork was used to communicate an inner experience, something was made concrete. Veterans reported that their artwork persisted over time. It is something tangible that “can’t be changed” but that functions as “a record of [their] journey”. It can thus be re-visited at a later stage and potentially explored from yet another angle. This particular function of art therapy also allows for bridging the gap between the art therapy session and after. The communicative effect of artwork can be carried over to other settings, and many shared positive experiences of using artwork to facilitate other therapy sessions such as CBT. Some reported the use of their artwork to open-up to people from their social environment.

Not a Cure

Veterans reported various impacts of art therapy beyond any experiences during the sessions. It is important to note that all participants agreed that AT did not offer a cure for their difficulties. In addition, most argued that the effects were somewhat transient with difficulties re-emerging after some time back in their daily lives.

Defusing PTSD Symptoms

Table 13.

Subcategory of “defusing” PTSD symptoms with its properties and quotes.

<u>Property</u>	<u>Illustrative quote</u>
“opening-up”	Dave: “I think because I come from a very military background, and quite a bloke-y world, we didn’t, certainly in the military you’re taught not to show emotion, you’re taught not to share things. Just shut up and get on with your job. And when you’re being questioned, just questions fired at you, you lock up straight away it’s sort of a defensive thing [...] Whereas with the art, it’s almost instantaneous that it’s open.”
“less fierce nightmares”	Chris: “But I mean I’m at a far better, happier place now, ‘cause I still get the bad nightmares. They don’t go away like you say, that doesn’t change but how I get up and cope with that definitely has. And how I get over that. Definitely I can function. Before I couldn’t function for days. It took a week to get over sometimes. Now, still get it but yeah functioning a lot better and I can talk about it more as well.”
“defusing the memory”	Thom: “But with the memories that you get with PTSD, they don’t. They stay there, they’re in perfect detail, and they’re so close. Whereas the perspective of it is all wrong. It’s big, and it should be small. And it was only when I started incorporating that into this work that I realised that I was remembering everything wrong and the emotions are far too strong. And it actually corrected that problem, it defused the memory in effect. It negated it. Within one drawing. And yet it had been stuck in my mind for the thirty years, in the wrong form. But this one drawing [...] it defused it and I lost the anger, I corrected the sense of humiliation, that shouldn’t have been there, and it wasn’t there. [...] I don’t know if I can describe it, but as it clicked back, it came in with absolute clarity and closeness, and then it was almost as though it was shooting back down a tunnel. [...] it was there, close, and then whoosh, straight back down this tunnel, into the past, and became just an ordinary memory.”
“feeling more relaxed”	Joshua: “Before coming, I’d been coming here 16 years now. Erm, everything was just bottled up. And since I’ve been doing the art therapy I tend to be more relaxed.”
“emotional release”	Chris: “Yes, definitely there is a release of emotions.”

Nevertheless, it was felt that AT helped to “defuse” PTSD symptoms. All participants talked about being better able to “open-up” in response to accessing AT. For some, it appeared to also have an effect on nightmares in that they were experienced as “less fierce”. One veteran reported his experience of “defusing the memory” of a traumatic event supporting him to remember it more similarly to an ordinary memory. Veterans shared that they were “feeling

more relaxed” following their intervention and that they experienced an “emotional release” of bottled up negative affect.

A New Perspective

Table 14.

Subcategory of “a new perspective” with its properties and quotes.

<u>Property</u>	<u>Illustrative quote</u>
“sharing the pain”	Alex: “I also seen it with my colleagues in here, especially the Royal Marine. How his work came on, how he really opened up, how he would cry when explaining things. It was quite a sweet thing to be a part of. You know, in this roughy toughy world that I live in and operate in, it was nice to see that others were affected and felt the same way that I did.”
the self	Robert: “This is probably going to sound a bit different, but it’s like I’ve discovered something new. A new way of understanding myself. So just by doing the different drawings, you know, I say it comes from nowhere but it’s got to be there. And it feels like I’ve tapped into something which I didn’t know was there.”
the future	Chris: “It’s made me realise that there is a future because I’m looking at it. And I can see, and I put the future into the imagery. Would I have spoken about the future without doing the art therapy? Probably not because you don’t realise there is a future. The imagery helps you see that.”
“a sense of achievement”	Robert: “at the end it, for me I have a sense of achievement. Drawing, or creating pictures or anything like that is not something that I’ve never considered myself to be someone that can do it. And I’m quite sort of proud of what I’ve done, and to actually talk about it as well.”

Aside from effects upon symptoms of PTSD, interviewees reported to have gained “a new perspective” on various aspects of their lives through AT. Firstly, they were able to “share the pain” which made them realise that they were “not alone”. Secondly, some gained a new perspective of themselves. This might entail understanding oneself better and/or being “more kind/compassionate” with oneself. Figure 5 shows a revealing comparison of how Otis felt his self-image changed over his admission.



Figure 5. Artwork by Otis pertaining to the themes of ‘mirror’ (left) and ‘resources’ (right).

Moreover, veterans talked about a new perspective on their own future. Two interviewees stated that before accessing art therapy their “future wasn’t there” and instead they felt somewhat “stuck in the past”. For others this pertained more to becoming more hopeful and positive about the future. Finally, most veterans experienced a sense of “achievement” that was carried over beyond the therapy session; “achievement” on the one hand regarding the creation of meaningful artwork and on the other hand regarding having communicated something that had been hard to put into words.

The Aftershock

Table 15.

Subcategory of “the aftershock” with its dimensions and quotes.

<u>Dimension</u>	<u>Illustrative quote</u>
↑ “fluffy”/“fuzzy”	Otis: “The only thing I say is when you come out of it, you feel quite fuzzy.”
“tired”	Kurt: “But there is an aftershock later on, because the cogs whirl in your heads, and see other pictures and images... yes, it does tend to make you tired after a while. Because you’re discussing very important, and you’re going very deep, if you know what I mean. You know, very personal things. And there’s an aftershock.”
“drained”	Joshua: “And it’s like a mental drain. And you can come in here bright as a button, do your work and you leave and you’re absolutely exhausted mentally.”
↓ “panic”	Thom: “you feel exhausted and I find quite frequently I actually find myself physically shaking afterwards. And I know I’m not alone because you’ll often find that the group of veterans that have been doing the art therapy, we’ll all head down to the tea-making point and immediately brew up a cup of tea to drink, just to try to calm down and settle down.”

All veterans agreed that following an AT session there was a certain “aftershock” which encompasses a mostly unpleasant amalgamation of emotions as well as physiological reactions. Experiences were organised along a dimension ranging from “fluffy”/“fuzzy” on the more pleasant end of the spectrum over “tired” and “drained” to “panic”. Most were surprised about “the aftershock” as doing the work had not felt taxing in most instances. Kurt and Chris argued that “the aftershock” might be a direct consequence of “off it all goes” as the experienced emotional and physiological reactions during the session left participants feeling emotionally and physically exhausted.

Triangulation

Please refer to Table 16 for demographics of respondents for triangulation.

Table 16.

Demographics of participants interviewed for triangulation.

<u>Participant</u> <u>alias</u>	<u>Gender</u>	<u>Age (in</u> <u>years)</u>	<u>Triangulation role</u>	<u>Years of</u> <u>practising AT</u> <u>with veterans</u>
Frieda	female	40	art therapist	4
Beth	female	64	art therapist	16
Nancy	female	63	wife of veteran	n/a

By and large responses by participants interviewed for triangulation purposes were in concert with data from veterans. Art therapists and a veteran's wife positioned the group as an important component of AT. They also talked about the importance of selecting the right amount of people for each group. Similarities such as a shared "sense of humour", being "like-minded", and a military background were commented upon. Similar to ex-servicemen, therapists acknowledged some difference in terms of experience, motivation, and presentation. Regarding ground rules, only respecting each other and not to talk directly about traumatic experiences was mentioned. Beth offered a new insight compared to veterans in hypothesising that the group acted as a "container" for otherwise intolerable experiences.

The therapist's calmness was not commented upon. However, being non-judgmental and encouraging the same stance in group members was highlighted. Therapists also felt that balance between high and low control was best aimed for by giving veterans "lots of choice" and by encouraging ex-servicemen to engage without being directive. Beth and Frieda agreed with veterans on their own responsibilities. They added a further insight by commenting that themes were tailored to fit the specific group. Responsibility was highlighted for not only keeping artwork on file, but also to "keep imagery in mind" over the course of an admission so parallels could be drawn,.

Participants for triangulation also felt that AT was “active” and emotion-focussed. The unique property of combining verbal and non-verbal elements was highlighted. The temporal and phasic structure was felt to increase feelings of safety and control. The art-making phase was described as “individual” activity mirroring the veterans’ concept of “a private affair”. A range of art media was commented upon with a tenor of choice being dependent on preference and time available. Therapists reported their observation of imagery emerging in an unplanned way and to evolve over the course of the session. Interviewees agreed with veterans in that the interpretation stage was seen as meaning making process in a group effort.

Frieda, Beth, and Nancy stated that ideally AT can be used to “talk about something that’s normally not talked about”. In agreement with veterans, talking about artwork was felt to be easier than directly about their experience due to the creation of “a safe distance”. They discussed the property of communicating with the other group members but did not highlight art therapy’s ability to facilitate a communication with the self or the therapist. “Mirror experiences” when viewing each other’s work were felt to have powerful effects upon veterans such as a reported “emotional connection” between group members and reduction of experienced isolation.

As part of triangulation, the category of an emotional reaction during the art therapy session was produced akin to veterans’ sub-category of “off it all goes”. Respondents commented on a “sense of enjoyment”, a “calming” effect, surprise, as well as upon “getting [...] absorbed” in the work. Frieda and Beth observed veterans becoming distressed, overwhelmed, or tearful in sessions. Bodily reactions or thinking processes were not commented upon. Similar to the above discussed category of “making things concrete”, Beth and Frieda stated that “artwork ha[d] a life” and that it can be used to facilitate other therapies.

In terms of the longer term impact of AT, therapists commented on art therapy’s “contributions to all symptom clusters”. All three primarily talked about “overcoming

avoidance” and social isolation. Frieda observed “a soothing effect” of AT and a release of emotions. A new/better understanding of the self and more compassionate view of the self was observed by all. Nancy shared her husband’s positive experience through being able to normalise his difficulties. She also reported a sense of lasting enjoyment and happiness.

Discussion

This section will begin by summarising the main findings and building links to previous research. Subsequently, limitations, clinical implications and future research suggestions will be discussed before ending upon closing remarks.

Summary of Findings

Based on veterans' interviews it appeared that the well-functioning AT group along with a gentle but active art therapist formed the conditions to build trust. The category title of "the family" echoes Lobban's 'Band of Brothers' theme commonly described amongst veterans (Lobban, 2012). This may reflect Yalom and Leszcz' (2005) therapeutic factor of the 'recapitulation of the primary family' often found in therapeutic groups. Smith's (2016) literature review also identified group processes as frequently proposed therapeutic mechanism of AT for veterans. Part of being "on the same wavelength" was a shared sense of humour; a finding in line with Kopytin and Lebedev (2013) who emphasised the therapeutic function of humour in AT groups for veterans. Due to the nature of the group it might have served as a 'container' (Bion, 1970) in which harrowing experiences can be shared and strong emotions tolerated. Trust was felt to be required to engage in effective work. Herman (1992) posited that following traumatic events basic trust is lost causing a sense of isolation and alienation. She highlighted the power of a healing relationship and veterans' ability to build trust both to each other and their therapist was therefore likely to have facilitated recovery.

In line with existing literature, feeling safe was a condition for engaging in art therapy (Case & Dalley, 2014; Lobban, Mackay, Redgrave, & Rajagopal, 2018). Moreover, having a sense of control was highlighted by the participants as a helpful factor; a concept that has been deemed essential in trauma work (Hermann, 1992). The interplay between the use of both verbal and non-verbal parts of the brain was part of the developed model. Research suggests that during the art-making phase non-verbal parts of the brain that communicate in images,

emotions, and bodily sensations are stimulated (Lusebrink, 2004). This might explain the strength and breadth of experience that veterans reported under the category “off it all goes”. Through the reported process of “breaking the code” communication between the brain hemispheres might be improved thus assisting the integration of aspects of trauma (Collie, Backos, Malchiodi, & Spiegel, 2006; Gantt & Tinnin, 2009; Nanda, Gaydos, Hathorn, & Watkins, 2010).

When the aforementioned aspects come together in the right way, it is hypothesised here that AT can be used as a communication tool. Parallels may be drawn to Lobban’s (2012) theme of ‘opening up’ as well as to the identified therapeutic factors of ‘communication’ and ‘self-expression’ as part of a systematic review of AT for depression (Blomdahl, Gunnarsson, Guregård, & Björklund, 2013). Viewing and exploring each other’s artwork as a group task revealed commonalities across time and participants on one hand triggering reactions during the session and on the other strengthening trust further; a finding akin to a recent thematic meta-synthetic findings of group AT by Gabel and Robb (2017). It was furthermore reported to help veterans to normalise their experiences. This is in line with Yalom and Leszcz’ (2005) group therapeutic factor of ‘universality’. However, unlike verbal group psychotherapy, art therapy has the unique ability to make an inner experience concrete and tangible. It is likely that this serves the function of externalising the problem (White & Epston, 1990) allowing for mastery of (Avrahami, 2005) or for emotional distance to (Collie et al., 2006) painful experiences. The artwork can subsequently be transferred and made use of outside the art therapy room.

It is important to note that art therapy was not seen as offering a cure for military PTSD. Nevertheless, veterans shared an experienced decrease in nightmare severity (re-living), ability to open-up (avoidance), breaking free from social isolation and release of built-up emotions (negative affect), and feeling more at ease (hyper-arousal). In addition, veterans reported that

a new perspective was gained of the self and their future alongside a sense of achievement. It remained unclear whether and how long therapeutic gains were maintained as most described a re-emergence of difficulties following earlier AT.

Limitations

Treatment at Combat Stress was offered as a residential package. One veteran was interviewed after attending a six-week admission including CBT-based psychoeducation group sessions, occupational therapy, as well as individual therapy. The remaining eight veterans had attended a two-week art therapy only programme with either individual CBT or AT in addition to the group sessions. Most had previous treatment often using other therapeutic modalities. Consequently, it is difficult to attribute any reported effects to the treatment components. However, it could be argued that because of having been exposed to a variety of therapies over a number of years the respondents had become experts by (therapy) experience and might have been particularly able to comment on the treatment effects of AT.

Moreover, participants were with one exception recruited from a single treatment facility and received AT delivered by a small number of art therapists. Consequently, findings are somewhat difficult to transfer to some other contexts. Responses of Chris who received treatment elsewhere were reassuring as they fitted well into the developing theory. Nevertheless, all of Combat Stress treatment centres follow a similar approach to AT that had been developed at the centres over the years. The developed model describes how AT works at a residential treatment centre using a similar approach to AT.

As noted above, interviewed veterans had accessed a number of treatments prior to being interviewed. Their difficulties are therefore by definition entrenched and appear not to have been substantially ameliorated by the NICE-recommended therapies previously received. It would be important to hold this limitation in mind when attempting to apply the developed grounded theory to other veterans. Perhaps AT only works in the proposed way for those with

the most severe and most entrenched difficulties. This might reflect Johnson et al.'s (1997) finding that treatment gains following AT were largest in those with the most severe difficulties.

Finally, it is possible that participants perceived the primary researcher as part of their treatment team particularly since the Combat Stress logo was used as a header alongside the university logo in all communications. If that was the case, it may have been difficult for veterans to answer questions openly and honestly. Specifically any negative aspects of AT or lack of improvement following their admission may have been difficult to communicate. Moreover, it was acknowledged that there are many ways in which data can be elevated onto a theoretical level (Birks & Mills, 2011). The researcher's pre-conceptions (e.g., 'art therapy works', 'art-making enables tapping into the unconscious') were likely to have shaped the final model.

Clinical Implications

It appeared that veterans accessing AT experienced distress both during and after the session. It would therefore be imperative for therapists to have appropriate training and qualification to identify signs of distress. Art therapists should also have tools at their disposal to help ex-servicemen return to their 'window of tolerance' between too much and too little arousal (Siegel, 1999).

Veterans were in agreement about the usefulness of utilising artwork to facilitate other types of therapy. Clinical psychologists working with traumatised adults may capitalise on that by co-working with or signposting to art therapists. It may be particularly useful when service-users find it difficult to put their experience into words due to avoidance (e.g., Keane & Barlow, 2002), memories being encoded in non-declarative parts of the brain (Brewin et al., 1996), or strong feelings of guilt/shame (Litz et al., 2009). Certain aspects of or perhaps around the

trauma can be explored through artwork and it may subsequently be used as a launch-pad for trauma-focussed psychological work.

In accordance with previous recommendations, fostering a sense of control without risking an unstructured environment that cannot serve a container function (Bion, 1970; Herman, 1992) appeared to play an important role for interviewees. Therapists using any model, art therapy or otherwise, may be well advised to keep this in mind when working with traumatised adults. There appeared to be a ‘point in the middle’ in terms of control and therapists are invited to consider how the right balance can be struck.

Research Directions

In order to establish the validity of the presented model it may be useful to conduct similar projects at other sites or with other groups. Most published research into AT for people with traumatic disorders describes one-to-one interventions (Schnitzer, in preparation) and it is possible that different mechanisms are at work. Exploration of active ingredients in the work with non-military trauma or other commonly worked with presentations (e.g., psychoses: Holtum, Huet, & Wright, 2017) may help to establish common mechanisms of change across settings, modes, and presentations. Furthermore, quantitative tools (e.g., Revised Impact of Event Scale; Weiss, 2007) may be used to investigate elements of the presented grounded theory such as potential symptom reduction following AT. Commonalities and differences could subsequently be used to develop AT programmes specific to mode and presentation with maximised effectiveness.

Veterans also alluded to a state during art-making that appeared akin to Csikszentmihalyi’s states of flow (2000). Flow describes the subjective phenomenological experience of intrinsically motivated activity. The state is characterised by intense and focussed concentration, loss of reflective self-consciousness, a sense of being in total control of one’s actions, distortion of temporal experience, and experience of the activity as intrinsically

rewarding. Flow was found to be enjoyable and energising (Nakamura & Csikszentmihalyi, 2014). Csikszentmihalyi's semi-structured interview or the Flow Questionnaire (Csikszentmihalyi & Csikszentmihalyi, 1988) may be used to establish whether veterans are 'in flow' during AT. Research has shown that being 'in flow' was associated with commitment to and persistence in the activity (Nakamura & Csikszentmihalyi, 2014). Fostering flow in AT may thus motivate participants to continue with their therapy and engage in it fully.

Lastly, all participants highlighted that difficulties re-emerged after some time back in their usual environment warranting further support at a later stage. It would be important to investigate this further. Several hypotheses were made during the project none of which could be (dis-)confirmed as part of the interviews. For instance, it is possible that Combat Stress provided a unique environment away from veterans' home lives. Re-occurrence of difficulties may therefore be explained by re-entering a world of triggers. Additionally, it has been hypothesised that partners not involved in PTSD treatment may disrupt the recovery process (e.g., Blount, Fredman, Pukay-Martin, Macdonald, & Monson, 2015) and Monk et al. (2017) reported beneficial effects through their participation. Another possibility was that veterans had experienced a number of traumas. Processing one trauma may offer some respite but other traumatic events or different aspects of the same event may come to the fore over time. However, this re-occurrence was reported following combined therapies including those recommended by NICE, not with AT alone. It is also possible that art therapy's effects and those of other therapies are temporary comparable to a plaster that falls off after a certain amount of time. It may be helpful to firstly establish a time-line of lapses and secondly to explore the specific nature of re-emerging difficulties and whether or not they are qualitatively different to those pre-treatment.

Closing Remarks

The current grounded theory project hypothesised several active ingredients of group art therapy for military PTSD as identified by veterans and largely corroborated by two art therapists and to some extent by one spouse. Main components were the art therapy group and the art therapist who enabled building of trust. A number of properties and dimensions of effective therapeutic work were postulated. Ideally veterans were enabled to use artwork as a communication tool. Physiological, cognitive, and emotional reactions during the session as well as longer term impacts of art therapy were discussed. The developed model was consistent with previously hypothesised mechanisms of change in art therapy that by and large had been untested, and were not produced by systematic research. It is hoped that presented findings are investigated further with the ultimate aim of perfecting art therapy for military veterans with PTSD; a goal consistent with the Ministry of Defence's five year strategy (MOD, 2017) to improve the mental health of its workforce. However, art therapy like many other individualised treatment approaches, may be limited by not taking account of veterans' social networks. This may be an important issue in future research on this modality.

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Gabriel Schnitzer, BSc MSc

Section C

Appendices of Supporting Materials

ACCURATE WORD COUNT:

not applicable

Appendix A: Examples of Art Therapies Offered

Example of a Theory-driven and Well Described Intervention

Hass-Cohen et al. (2014) was selected as an example for a theory-driven and well described art therapy intervention. In their introduction the authors give a detailed account of up-to-date neuro-psychological findings regarding PTSD. Hass-Cohen et al. discuss short-term and long-term responses to extreme stress and embed processes in the relevant structures of the central and peripheral nervous system. Links are made as to the ways in which art therapy could impact beneficially on those neurobiological changes.

The authors used an art therapy protocol that can be replicated with the appropriate training. The layman reader is able to form an idea of how the sessions were facilitated with their service-user. An excerpt of the protocol's description is quoted below:

The Check art therapy protocol is comprised of five art directives offered in the following sequence: (a) autobiographical trauma timeline, (b) trauma image drawing and narration, (c) image alteration, (d) self-strength image, and (e) optimistic future image. The protocol is based on Herman's (1997) tri-phasic model, established trauma treatment approaches (e.g., Courtois & Ford, 2013), and the neurobiology of fear and resiliency as reviewed above.

[...] The first directive, to “draw an autobiographical timeline of the traumatic event,” allows the client to start placing traumatic events in the past, differentiating them from the here and now. The second directive, “if you were to paint or draw what happened, or an aspect of it that you feel comfortable representing, what would it look like?” exposes traumatic memories of the event. Next, a title for the art piece and accompanying written narrative are shared with the therapist, which helps integrate emotive and cognitive processing and reduces cognitive distortions.

After saving a digital image of the artwork, the client responds to the third directive: “check in; if you could change or keep one aspect of the drawing or painting, which aspect would you choose and what does it look like?” The therapist communicates that the client “may cut it out, keep or throw away the cutout, and/or paint over it using the background color” of the paper. “Consider painting, drawing, or gluing on additional images,” the directive continues, “or glue the rescued parts on a fresh page and start afresh.” Next the client titles and describes the altered artwork, noticing the difference between the two images. This process helps to increase the client’s internal sense of control and emotional awareness as it also decreases arousal and/or dissociative responses. To promote resiliency, the next two directives are to “draw your strengths” and to “draw an image of what an optimistic future would look like.” The therapist provides a choice of media on a nearby table, allowing clients to select and bring materials closer to their art-making space (Hass-Cohen et al., 2014, pp. 72-73).

Example of Intervention Lacking Theory and Description

Merriam (1998) was selected as an example of art therapy that was not clearly underpinned by theory and lacked a detailed description that would enable a reader to replicate the intervention. The author discusses some research on the effects of art therapy as well as a limited number of untested hypotheses of how art therapy might work. However, she fails to convince the reader of a sound underlying theoretical basis.

Moreover, it is unclear how Merriam worked with her service-users. The description of the sessions are vague. As part of her case-studies she describes imagery created in the sessions but not whether any instructions were given or not. Additionally, it is unclear whether any of the interpretations mentioned in the article were shared with the service-users or how they were reached.

Art therapy is described as follows:

Art therapy provides incarcerated women with a voice when they have otherwise lost their ability to verbalize their emotions because of trauma. This makes art therapy particularly beneficial to women with a history of trauma, because an inability to describe and discuss trauma creates tremendous obstacles for therapeutic intervention. [...]

I try to instill this [self-directedness] in the women I work with by providing a client-directed approach where they are encouraged to attain control by choosing and manipulating the art materials. The structure is the art activity itself, and boundaries are marked by the paper edge. [...]

I receive their art work with serious interest and a willingness to understand. The clarifications and responses I offer facilitate their increasing awareness of the meaning of their images and over time there is a growing sense of sharing in these images, even though no words may be exchanged about them (Merriam, 1998, p. 159).

Appendix B: Initial Semi-structured Interview Schedule

- 1.) How did you find the art therapy programme?
 - Does anything stand out as especially memorable from art therapy, or not? If so what, and what is it about that that stays in your mind?
 - Was art making a new experience for you, or not?
 - Was it a positive/negative experience? Enjoyable/not enjoyable?
 - What about it did you like/dislike?
- 2.) What, if anything, was the impact of art therapy?
 - Was it on the whole helpful/unhelpful?
 - (If perceived as helpful) How did it help you? Could you say a bit more about that? Why do you think that was helpful for you? What changed for you?
 - (If not perceived as helpful) From your perspective, what got in the way of benefitting from it? / What was unhelpful about it?
 - Was there something about art making that particularly influenced your experience of art therapy? If so, what do you think it was?
 - How did you find the process of viewing and discussing participants' artworks in the group?
 - Did art therapy have any other impacts?
- 3.) What was most helpful/least helpful about art therapy?
 - Did it make any difference in terms of how you understand yourself or your life at all? If yes, what changed?
 - Do you see yourself or the world any different now? If yes, what has changed?
 - Were you able to resolve anything that had not been resolved before?
 - If you could change anything about art therapy to make it more effective, what would it be?
 - If you found art therapy helpful, how do you think it works?
 - How would you describe how it works to a friend/spouse?
 - If you had to try and say which aspects of art therapy are the "active ingredients", what would you say?
- 4.) (if people had other therapy before, or received a care package including other modalities) What, if anything, did you get out of art therapy that you did not get from other/previous therapy?
 - In what way is art therapy different to other therapy approaches?

- In your opinion, is it better/worse/same than/as other therapies? How so?
- 5.) Is there anything else you would like to say about your experience of art therapy – maybe something we haven't covered?

Recorder off

Debriefing

Appendix C: Ethics Approval Letter

[This has been removed from the electronic copy]

Appendix D: Info-sheets



Information about the research

Study: Art Therapy for combat stress – Does it work, and if so, how?

Hello. My name is Gabriel Schnitzer and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.

(Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?

Art therapy is an integral part of the treatment package at Combat Stress. The aim of my project is to find the “active ingredients” of the treatment approach. I am therefore interested in asking people who have received art therapy and those who deliver it about their experience with it, if they found it helpful and about their view on its possible mechanisms of change. I would also like to interview partners of those who have received art therapy about their observations following treatment. The results of the project can afterwards be used to improve existing programmes and to make a stronger case for the use of art therapy in treating post-traumatic stress.

Why have I been invited?

You have been invited because you participated in the art therapy programme. I have consulted the art therapists who have helped me to identify people who seemed interested in sharing their experience. I will interview approximately 10 to 14 people in total as part of this project. I will interview veterans who have received art therapy, their partners, and art therapists working with veterans.

Do I have to take part?

It is important for you to know that taking part in this study is entirely up to you. If you agree to be interviewed, I will ask you to sign a consent form. You can withdraw your consent at any time, without giving reason. This would not have any impact on the care you receive whatsoever.

What will happen to me if I take part?

If you take part I will first give you a short questionnaire. I will then ask you a series of questions some of which I have prepared and some of which I will ask based on the answers you have given me. The interview will last approximately 1 hour and won't be longer than 1.5 hours. I will audio-record the interview in order to analyse your responses afterwards. I will keep the audio-file password protected and encrypted on a secure server for five years. Any transcripts and snippets for my final thesis will be completely anonymised. In my project I will use a specific research method that allows for developing a theory from interview responses. If you agree to your partner taking part in the study, I would like to contact them and invite them to take part. They are not obliged to take part only because you are taking part.

Expenses and payments

If you have travelled here specifically to participate in the research you are entitled to up to £10 for your travel expenses. You will, however, not be paid for taking part in the study.

What will I be asked to do?

I simply ask you to answer my questions as openly and honestly as possible. It's important to remember that there are no right or wrong answers. I am interested in your personal experience with art therapy and your thoughts about how it works. I encourage you to ask for clarification if a question is unclear. It is also okay to not know or to decide not to answer a specific question if you don't wish to.

What are the possible disadvantages and risks of taking part?

We will be talking about your experience at Combat Stress. I will not ask you any questions about your traumatic experiences but talking about your recovery may still "stir things up". Please, do let me know if the interview becomes distressing and we can pause or end immediately and we can try to manage your distress together. You might also wish to think of a person with whom you could discuss the interview experience afterwards, should this be helpful, for example if you felt troubled by thoughts or memories after the interview. This can be a friend, spouse, or your GP. [art therapist] will also be available in case you wish to talk to someone at Combat Stress [01372 587032, [art therapist]@combatstress.org.uk]. You can also contact Combat Stress and ask for the Duty Nurse who will be able to support in any acute crises resulting from the interview process [01372 587080].

What are the possible benefits of taking part?

Taking part in this study is unlikely to help you personally. The results of the project on the other hand may help to improve the treatment of people with combat stress.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?

If you withdraw from the study we will end the interview immediately. This will not have any impact on your care. In that case I would like to use the data collected up to your withdrawal.

What if there is a problem?

We will take any complaints seriously. Please feel free to raise any concerns in the interview with me. If you don't wish to raise an issue during the interview I encourage you to follow the complaint procedure below.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions – 0333011 7070 (please leave a message and **state that it is for Gabriel Schnitzer**, I will get back to you as soon as possible, don't forget to leave your contact details). If you remain unhappy and wish to complain formally, you can do this via Prof Paul Camic, Research Director, Salomons Centre for Applied Psychology, Canterbury Christ Church University – paul.camic@canterbury.ac.uk. You may also wish to file a complaint with Combat Stress. In that case please, contact [art therapist].

Will my taking part in this study be kept confidential?

All information collected about or from you during the course of the research will be kept strictly confidential, and any information about you which leaves the Combat Stress Centre will have your name and address removed so that you cannot be recognised. Please also note that I will not share anything you have said in your interview with your partner should they agree to be interviewed, too. I will keep the audio files of our interview password protected and encrypted on a secure server. Any transcripts and excerpts for publication and as part of my thesis will be exhaustively anonymised so that you cannot be recognised. My supervisors Dr Sue Holttum and Dr Val Huet may access the audio recording and transcript if need be. The anonymised interview transcripts will also be kept at Canterbury and Christ Church University on a password-protected CD for five years.

What will happen to the results of the research study?

I will use your and the other participants' responses to develop a theory about how art therapy works for veterans experiencing combat stress. Once the study is completed I will write my doctoral thesis about the research which will be reviewed by the examination board of Canterbury and Christ Church University. I also intend to submit a condensed version of my thesis for publication in a scientific journal. Please note that anonymised quotes from participants' interviews will be included in the thesis and publication. If you are interested in the results you can give me an email address and I will send you a message with the details of the outcome in due course. You will also have the opportunity to comment on the theory of how art therapy works before it is finalised. I would be interested to know how well the preliminary version fits with your personal experience.

Who is organising and funding the research?

This study was initiated by the British Association of Art Therapists and Combat Stress. Canterbury and Christ Church University is facilitating the project.

Who has reviewed the study?

All research is looked at by independent group of people to protect your interests. This study has been reviewed and approved by the Salomons Ethics Panel on 28/09/2016. It has also been reviewed and approved by the Combat Stress Ethics Panel.

Further information and contact details:

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 0333011 7070. Please **say that the message is for me, Gabriel Schnitzer**, and leave a contact number so that I can get back to you.

If you would like additional support in deciding whether or not to participate in the research, please feel free to discuss this with [art therapist]. They are aware of the scope of the study as well as of any potential risk.

In case you have any concerns during the interview and you feel less able to raise those directly with me, please contact [art therapist] or the Duty Nurse.



Information about the research

Study: Art Therapy for combat stress – Does it work, and if so, how?

Hello. My name is Gabriel Schnitzer and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

(Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?

Art therapy is an integral part of the treatment package at Combat Stress. The aim of my project is to find the “active ingredients” of the treatment approach. I am therefore interested in asking people who have received and those who deliver art therapy about their experience with it and about their view on its possible mechanisms of change. The results of the project can afterwards be used to improve existing programmes and to make a stronger case for the use of art therapy in treating post-traumatic stress.

Why have I been invited?

You have been invited because you facilitate art therapy programme for veterans. I will interview approximately 10 to 14 people in total as part of this project. I will interview veterans who have received art therapy and art therapists working with veterans.

Do I have to take part?

Taking part in this study is entirely up to you. If you agree to be interviewed, I will ask you to sign a consent form. You can withdraw your consent at any time, without giving reason.

What will happen to me if I take part?

If you take part I will first give you a short questionnaire. I will then ask you a series of questions some of which I have prepared and some of which I will ask based on the answers you have given me. The interview will last approximately 1 hour and won't be longer than 1.5 hours. I will audio-record the interview in order to analyse your responses afterwards. I will keep the audio-file password protected and encrypted on a secure server for five years. Any transcripts and quotations for my final thesis or as part of a publication will be completely anonymised. In my project I will use a specific research method that allows for developing a theory from interview responses.

Expenses and payments

If you have travelled here specifically to participate in the research you are entitled to up to £10 for your travel expenses. You will, however, not be paid for taking part in the study.

What will I have to do?

I simply ask you to answer my questions as openly and honestly as possible. I am interested in your personal experience with delivering art therapy and your thoughts about how it works. I encourage you to ask for clarification if a question is unclear.

What are the possible disadvantages and risks of taking part?

Disadvantages or risk are unlikely to occur. If, however, the interview becomes distressing, do let me know and we can pause or end the interview.

What are the possible benefits of taking part?

Taking part in this study is unlikely to help you personally. The results of the project on the other hand may help to improve the treatment of people with combat stress.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

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If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

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If you withdraw from the study we will end the interview immediately. In that case I would like to use the data collected up to your withdrawal.

What if there is a problem?

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Complaints

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions – 0333011 7070 (please leave a message and **state that it is for Gabriel Schnitzer**, I will get back to you as soon as possible, don't forget to leave your contact details). If you remain unhappy and wish to complain formally, you can do this via Prof Paul Camic, Research Director, Salomons Centre for Applied Psychology, Canterbury Christ Church University – paul.camic@canterbury.ac.uk.

Will my taking part in this study be kept confidential?

All information collected about or from you during the course of the research will be kept strictly confidential, and any information about you which leaves the Combat Stress Centre will have your name and address removed so that you cannot be recognised. I will keep the audio files of our interview password protected and encrypted on a secure server. Any transcripts and excerpts for publication and as part of my thesis will be exhaustively anonymised so that you cannot be recognised. My supervisors Dr Sue Holtum and Dr Val Huet may access the audio recording and transcript if need be. The anonymised interview transcripts will also be kept at Canterbury and Christ Church University on a password-protected CD for five years.

What will happen to the results of the research study?

I will use your and the other participants' responses to develop a theory about how art therapy works with veterans with PTSD. Once the study is completed I will write my doctoral thesis about the research which will be reviewed by the examination board of Canterbury and Christ Church University. I also intend to submit a condensed version of my thesis for publication in a scientific journal. Please note that anonymised quotes from participants' interviews will be included in the thesis and publication. If you are interested in the results you can give me an email address and I will send you a message with the details of the outcome in due course. You will also have the opportunity to comment on the theory of how art therapy works before it is finalised. I would be interested to know how well the preliminary version fits with your personal experience.

Who is organising and funding the research?

This study was initiated by the British Association of Art Therapists and Combat Stress. Canterbury and Christ Church University is facilitating the project.

Who has reviewed the study?

All research is looked at by independent group of people to protect your interests. This study has been reviewed and approved by the Salomons Ethics Panel on 28/09/2016. It has also been reviewed and approved by the Combat Stress Ethics Panel.

Further information and contact details:

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 0333011 7070. Please **say that the message is for me, Gabriel Schnitzer**, and leave a contact number so that I can get back to you.



Information about the research

Study: Art Therapy for combat stress – Does it work, and if so, how?

Hello. My name is Gabriel Schnitzer and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

(Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?

Art therapy is an integral part of the treatment package at Combat Stress. The aim of my project is to find the “active ingredients” of the treatment approach. I am therefore interested in asking people who have received and those who deliver art therapy about their experience with it and about their view on its possible mechanisms of change. Additionally, I am interested in talking to partners of those who have received art therapy about their observations following treatment. The results of the project can afterwards be used to improve existing programmes and to make a stronger case for the use of art therapy in treating post-traumatic stress.

Why have I been invited?

You have been invited because your partner has received art therapy and they agreed for me to contact you. I will interview approximately 10 to 14 people in total as part of this project. I will interview veterans who have received art therapy, their partners and art therapists working with veterans.

Do I have to take part?

Taking part in this study is entirely up to you. If you agree to be interviewed, I will ask you to sign a consent form. You can withdraw your consent at any time, without giving reason.

What will happen to me if I take part?

If you take part I will first give you a short questionnaire. I will then ask you a series of questions some of which I have prepared and some of which I will ask based on the answers you have given me. The interview will last approximately 1 hour and won't be longer than 1.5 hours. I will audio-record the interview in order to analyse your responses afterwards. I will keep the audio-file password protected and encrypted on a secure server for five years. Any transcripts and quotations for my final thesis or as part of a publication will be completely anonymised. In my project I will use a specific research method that allows for developing a theory from interview responses.

Expenses and payments

If you have travelled here specifically to participate in the research you are entitled to up to £10 for your travel expenses. You will, however, not be paid for taking part in the study.

What will I have to do?

I simply ask you to answer my questions as openly and honestly as possible. I am interested in your personal experience with delivering art therapy and your thoughts about how it works. I encourage you to ask for clarification if a question is unclear.

What are the possible disadvantages and risks of taking part?

Disadvantages or risk are unlikely to occur. If, however, the interview becomes distressing, do let me know and we can pause or end the interview.

What are the possible benefits of taking part?

Taking part in this study is unlikely to help you personally. The results of the project on the other hand may help to improve the treatment of people with combat stress.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?

If you withdraw from the study we will end the interview immediately. In that case I would like to use the data collected up to your withdrawal.

What if there is a problem?

We will take any complaints seriously. Please feel free to raise any concerns in the interview with me. If you don't wish to raise an issue during the interview I encourage you to follow the complaint procedure below.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions – 0333011 7070 (please leave a message and **state that it is for Gabriel Schnitzer**, I will get back to you as soon as possible, don't forget to leave your contact details). If you remain unhappy and wish to complain formally, you can do this via Prof Paul Camic, Research Director, Salomons Centre for Applied Psychology, Canterbury Christ Church University – paul.camic@canterbury.ac.uk.

Will my taking part in this study be kept confidential?

All information collected about or from you during the course of the research will be kept strictly confidential, and any information about you which leaves the Combat Stress Centre will have your name and address removed so that you cannot be recognised. I will keep the audio files of our interview password protected and encrypted on a secure server. Any transcripts and excerpts for publication and as part of my thesis will be exhaustively anonymised so that you cannot be recognised. My supervisors Dr Sue Holtum and Dr Val Huet may access the audio recording and transcript if need be. The anonymised interview transcripts will also be kept at Canterbury and Christ Church University on a password-protected CD for five years. Please also note that I will keep the responses of your partner who has already been interviewed confidential and I will not refer to his/her views. I am not permitted to answer any questions you might have about their experiences and views of art therapy.

What will happen to the results of the research study?

I will use your and the other participants' responses to develop a theory about how art therapy works with veterans with PTSD. Once the study is completed I will write my doctoral thesis about the research which will be reviewed by the examination board of Canterbury and Christ Church University. I also intend to submit a condensed version of my thesis for publication in a scientific journal. Please note that anonymised quotes from participants' interviews will be included in the thesis and publication. If you are interested in the results you can give me an email address and I will send you a message with the details of the outcome in due course. You will also have the opportunity to comment on the theory of how art therapy works before it is finalised. I would be interested to know how well the preliminary version fits with your personal experience.

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Further information and contact details:

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 0333011 7070. Please **say that the message is for me, Gabriel Schnitzer**, and leave a contact number so that I can get back to you.

Appendix E: Informed Consent Form



Participant Identification Number for this study:

CONSENT FORM

Title of Project: Art Therapy for combat stress – Does it work, and if so, how?

Name of Researcher: Gabriel Schnitzer

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
3. I agree to audio-record my individual interview. ☐
4. I understand that relevant sections of my data collected during the study may be looked at by the researcher's supervisors Dr Sue Holttum and Dr Val Huet. I give permission to Dr Sue Holttum and Dr Val Huet to have access to my data. ☐
5. I agree that anonymous quotes from my interview may be used in published reports of the study findings. ☐
6. I agree to art that I have made as part of art therapy to be included into the doctoral thesis and publication. I understand that I can choose pieces of art for publication and that my art work will not be identified as mine without my written consent to be named (can be given optionally on a separate form). ☐
7. I agree to take part in the above study ☐

Name of Participant _____

Date _____

Signature _____

Name of Person taking consent _____

Date _____

Signature _____

Appendix F: Initial Questionnaire



Art Therapy: Does it Work, and if so, How?

Initial Questionnaire

Participant ID:	
Age (in years):	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say
Ethnicity (please tick most appropriate):	<input type="checkbox"/> White British <input type="checkbox"/> Asian British <input type="checkbox"/> White Other <input type="checkbox"/> Asian Other <input type="checkbox"/> Black British <input type="checkbox"/> Mixed <input type="checkbox"/> Black Other <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to say
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Co-habiting <input type="checkbox"/> Married <input type="checkbox"/> Window(er)/divorced <input type="checkbox"/> Prefer not to say
Employment status:	<input type="checkbox"/> Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Unemployed <input type="checkbox"/> Long-term sick/disabled <input type="checkbox"/> Retired <input type="checkbox"/> training/educational <input type="checkbox"/> Self-employed <input type="checkbox"/> Prefer not to say

Length of active service (in years):	<input type="checkbox"/> Prefer not to say
Have you had any psychological treatment before your current treatment at Combat Stress?	<input type="checkbox"/> No <input type="checkbox"/> Yes. How many individual episodes? _____ <input type="checkbox"/> Prefer not to say
Have you had Art Therapy before?	<input type="checkbox"/> No <input type="checkbox"/> Yes. How many individual episodes? _____ <input type="checkbox"/> Prefer not to say
Are you currently taking any medication?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Please specify (please refer to list) _____ <input type="checkbox"/> Prefer not to say

Appendix G: Initial Code Clusters

- EFFECTIVENESS OF AT PROGRAMME (PROPERTY)
- WORKING THROUGH PAST EXPERIENCES (CATEGORY)
- STRUCTURE OF AT (CATEGORY)
- INTERPRETATION STAGE
- (SYMPTOMS/SIGNS (?) OF) MILITARY PTSD (CATEGORY)
- TRIGGERS THINKING PROCESS/COGNITIVELY ENGAGING (C)
- THE AT ENVIRONMENT/SETTING (C)
- USE OF LANGUAGE/NON-VERBAL VS. VERBAL (P)
- CONFIDENTIALITY (SC TO GROUP RULES?)
- THINKING PROCESS/COGNITIVE EFFORT (?) (P)
- FEELING SAFE (P ??)
- CONTROL (P)
- CONTAINMENT (P)
- ART MEDIUM (C)
- COLOUR (P OF ART MEDIUM)
- QUALITY/SKILLS (P)
- DIFFERENT ANGLES/A NEW ANGLE (P OF IMPACT ??)
- UNDERSTANDING
- EXCAVATING BURIED MEMORIES (SUBC OF IMPACT)
- MEANING MAKING
- TAPPING INTO THE UNCONSCIOUS (SUBC OF IMPACT)
- TRUST AS A REQUISITE (BOTH GROUP AND THERAPIST)
- TECHNIQUES OF AT
- KEEPING A RECORD
- THE CREATIVE PROCESS
- STRUCTURED APPROACH
- EFFORTLESSNESS (P)
- THE THERAPIST (C)
- VOICE (P)
- INVOLVEMENT ?? (P)
- TRUST (P)
- CONFIDENCE/PERSONALITY (P)
- TRAINING/QUALIFICATION (P)
- APPROACH

- TIME SPENT TOGETHER
- EMOTIONAL/PHYSIOLOGICAL REACTIONS
- TIRING/EXHAUSTING (C OR P TO IMPACT)
- INTEGRATION OF BRAIN HEMISPHERES (SUBC OF IMPACT)
- VALUE JUDGEMENTS (P ??)
- SOMETHING ABOUT UNKNOWN MECHANISM
- LONGEVITY/TRANSIENCE OF EFFECTS (P)
- THE GROUP
- MUTUAL (EMOTIONAL) SUPPORT (P)
- SIMILARITIES AMONGST MEMBERS/COHESION (P)
- RESILIENCE
- GROUND RULES
- SOCIAL LEARNING
- GROUP SIZE
- TIME SPENT TOGETHER
- SPEED/PACE OF PROCESS (P)
- EMOTIONAL RELEASE/RELIEF/LETTING THINGS GO/PROCESSING EMOTION (SUBC TO IMPACT)
- 'POINTS OF RECOGNITION'
- BARRIERS
- DELAYED/TIMING OF ONSET (P)
- SYMBOLS (SUBC OF TECHNIQUES ??)
- INSIGHT/PSYCHOEDUCATION
- EXPERIENTIAL LEARNING/THERAPY (C) (technique ??)
- IMPACT ON SYMPTOMS
- NIGHTMARES
- TRAUMATIC MEMORIES
- AVOIDANCE
- SLEEP
- HYPERVIGILANCE
- NEGATIVE AFFECT
- DIFFERENCE TO OTHER THERAPIES
- INTEGRATION OF SELF (??)
- STUCK IN THE PAST VS BEING IN HERE-AND-NOW
- BARING ONE'S SOUL
- AT AS ADJUNCT
- AT VS ART MAKING
- EXAMPLES EXAMPLES EXAMPLES
- NOT SURE

Appendix H: Sample Memo

07.11.2017

Memo 2: Feeling safe

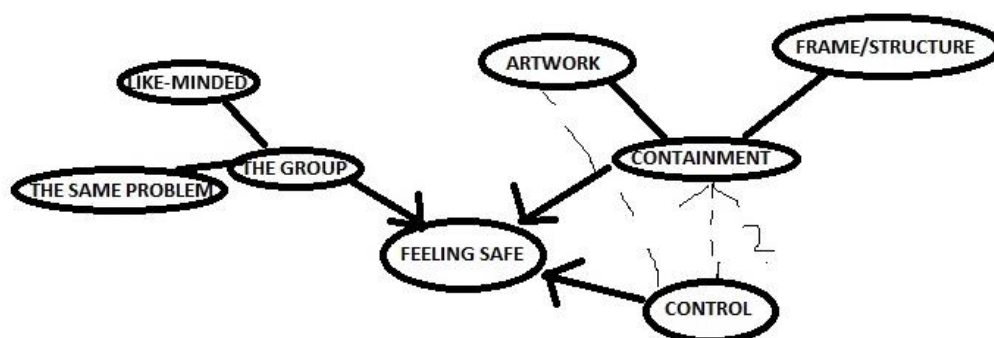
Veterans have talked directly and indirectly about feeling safe during AT. I wonder what that is about. Does AT and the specific structure of it provide veterans with a sense of safety; a feeling that must stand in stark contrast to traumatic events in the past and potentially flashbacks bringing trauma into here-and-now? Is the provision of a safe space in itself therapeutic?

"I think that this place in particular, if you come here you meet like-minded people, so all your guards are dropped. You don't feel any threat, you don't feel guarded, you don't need to tuck yourself away, in my case, you can just relax because you've got like-minded people here and they've all got the same problem."

This quote makes it sound like it. This also sheds some light on how this sense of safety is achieved: "like-minded people" having "the same problem". What comes to mind immediately is the Band of Brothers culture. One can only feel safe (to belong?) with "the boys". So is it the group that provides safety? Yes and no, I'd say. There's probably an important element of that, however, I believe that other factors contribute to this sense of safety. For instance, control makes people feel safe. Veterans have reported that AT gives them a sense of control, they feel in the driver's seat of their therapy (see Memo 1). Is there a link between control and feeling safe? Do veterans feel safe (partly) because they have some sense of control over the course of therapy?

What else helps veterans feel safe? Containment comes to mind; another (sub-)category identified in the data. Sessions happen in the same room, at the same time, following the same structure. An explicit and strict frame that I believe feels (on some level) containing to participants.

What about the medium of therapy? Working on a piece of art and thus innately creating distance between what's worked on on one hand and the experience/trauma on the other may also contribute to feeling safe in AT (at CS). People don't have to say 'X happened to me and it made me feel Y'. Instead participant talk about their artwork and what it might symbolise. They can chose how much the artwork and symbols within are linked explicitly to their own experience and life. Again, control, the artwork, and a sense of safety appear to be linked.



Update later same day:

There appears to be some evidence for the link between the above link between artwork, containment, and feeling safe. One veteran reported that:

“And if you’ve got to describe something in a group, you might be describing something horrible which is going to traumatise someone else in the group. But with the paper and the materials, you can use an analogy.”

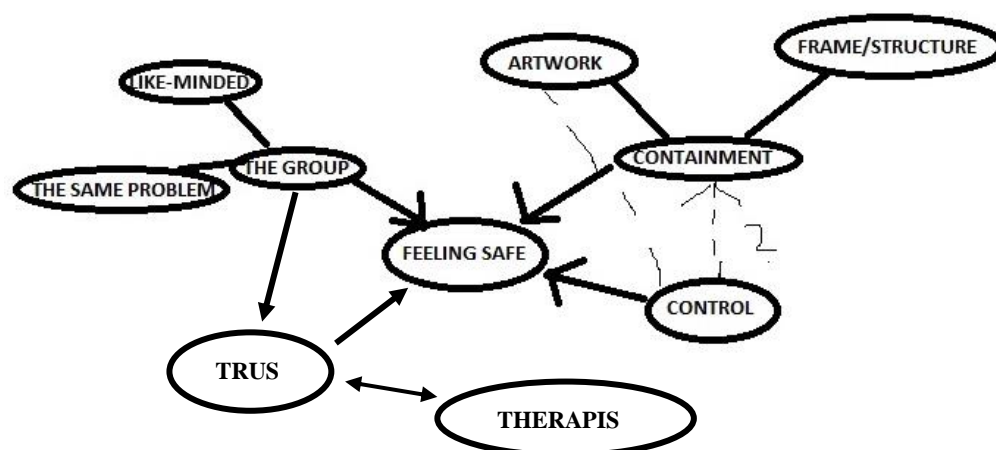
11.11.2017

Update

Trust is another important requisite for successful treatment it appears. I guess this is no different to any other type of therapy. I hypothesise that trust and feeling safe are inextricably linked. Is feeling safe the result of having built trust? Can you feel safe without trusting the group/therapist. I don’t think so. But can I back this up with data?

Also, what does one have to trust in for the therapy to work? Veterans mentioned trust in the other group members and the therapist. But what about trust in the therapy? The treatment centre? The possibility to recover and move on?

Finally, what helps to build trust? When it comes to group members, it appears that time spent together, confidentiality, and having been through similar things helps this process (see ‘trust’ code on NVIVO). Veterans are less explicit about what has helped them to develop trust to Beth. Is it her personality, training, time spent together? Is there anything about AT or the way it is delivered that helps to build trust?



12.11.2017

Update:

Alex: *“Yeah, I do, yeah. There’s something cathartic about, there’s something that frees you, as in ‘f’ ‘r’ ‘double e’. Frees you when you’re doing a doodle of how your thoughts are. Which I would never do at home. I would never draw myself with an unhappy face and a pint of Guinness nearby to simulate how I missed drink. Because I wouldn’t do that home, I would be drawing a picture of a soldier in Northern Ireland, or an armoured vehicle, and I would just not think of doing that because*

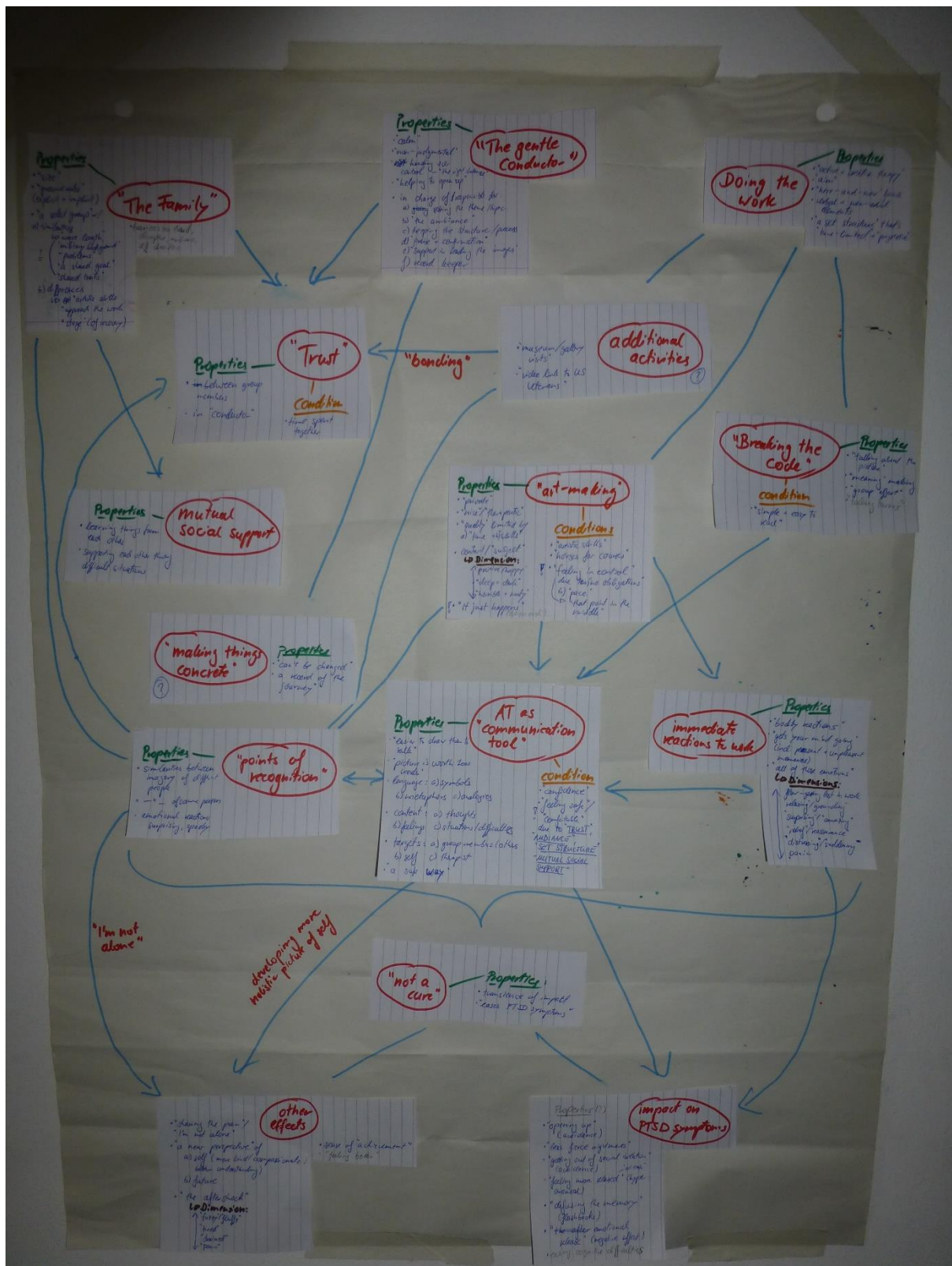
someone might see it and ask me questions about it, so I stick to non-doodle sort of drawings at home. And it's only since I've been here that I've done little pictures of myself and things like that, yeah."

This quote sounds to me to be tapping into the same process. The true nature and the true thoughts and feelings cannot be depicted in art for pleasure activities. It would be intolerable to be asked questions about it. The participant probably does not feel safe and would instead feel vulnerable and exposed. So in a way this indicates that it is not just (!) about the confinement to the paper and the distance created but other factors of AT not present at home (structure, group, therapist) are requisites. Maybe there is something about the combination of all these factors.

Appendix J: Refined Diagramme of Codes



Appendix K: Final Step Before Complete Theory Integration



Appendix L: Synopsis for Respondent Validation

Art Therapy with Veterans: Does it work and if so, how?

The following grounded theory aims to identify the active components of art therapy as delivered at Combat Stress. It furthermore attempts to trace its mechanisms of change and illustrate some of the effects of art therapy on veterans. Please note that italics are used for any in-vivo code, i.e., any element of the grounded theory that is described in participants' actual words. Higher-order categories of the model are underlined.

There are three main components of art therapy: 1) *the family* 2) *the gentle conductor* and 3) doing the work. *The family* or art therapy group is defined by its *size* and it has explicit and implicit *ground rules*. It was described as a *select group* whose members shared a range of similarities (a) *on the same wave length*, b) *military background*, c) similar problems, d) *a shared goal*). However, some differences are acknowledged such as a) being at *different stages* and b) having a *different approach to the work*. Similar to well-functioning family, within the art therapy group members can learn from each other and support each other through difficult experiences.

The second main component is *the gentle conductor* or the art therapist. Properties mentioned as part of the research were *being calm*, *non-judgmental*, being able to *help veterans to open-up*, and to find *the right balance* between taking control and handing it over to the participants. The *gentle conductor* is in charge of or responsible for: a) providing the theme/topic, b) providing the context, c) keeping the structure, d) support in reading the images, e) record keeper.

The family and *the gentle conductor* appeared to be conditions for building *trust*. *Trust* in turn was an important requisite for constructive work. Aside from the aforementioned properties of *the family* and *the gentle conductor* time spent together enabled participants to build trust.

The final active component was doing the work. Art therapy is an *active and creative therapy*. It has a clear *here-and-now focus* and combines *verbal and non-verbal* elements. It follows *a set structure* that is *time-limited* and *progressive*.

The art-making phase is a *private affair* and can be *therapeutic* in itself. What is produced are *heartfelt doodles* limited by a) *skills level* and b) *time*. The content or *subject* of the work is the experience of the veterans and not the trauma(s) they had been through. The *subjects* therefore range from *positive/happy*, over *deep and dark* to *horrible and nasty*. Participants described how *it just happens* and images seemed to come up *automatically* and *effortlessly*. Conditions for art-making were a certain level of *artistic skills* (but this did not seem to be a requirement) and freedom to choose art materials based on preference (*horses for courses*). Participants talked about *that point in the middle* between high and low *control* feelings most helpful for effective work. *Control* was moderated by *not being obliged* (to draw, speak, work with a certain medium etc.).

Once the artwork has been completed the phase of breaking the code commences. In this phase participants *talk about their picture* and it is attempted to make sense of it or establish its *meaning*. This is a *group effort* and *participants take turns*. A condition for breaking the code appeared to be *simple and easy to read* drawings.

The final aspect of art-making was the category *off it all goes* subsuming a number of reactions to the work during the sessions. Reactions encompassed the entire experience of participants. Veterans talked about *bodily reactions* whilst working on their artwork. Focussing their minds of the piece of art also *gets your mind going* and a thinking process is triggered potentially including both pleasant and unpleasant memories. The main reaction was emotional. A wide range of *all those emotions* was reported from 'flow' experiences (*getting lost in the work*), over a *relaxing/grounding* reaction, and *surprise/amazement*, *relief/reassurance*, to saddening/distressing, and finally *panic*. The supportive function of the family enabled members to endure and contain strong emotions.

When these ingredients come together in the right way, art therapy can be used as a communication tool. *It is easier to draw than to talk* and *a picture is worth a thousand words* (carries a lot meaning). The language of the communication are *symbols, metaphors, and analogies*. The content can be *thoughts, feelings, and situations/specific difficulties*. Recipients are a) other group members, b) the self ("I don't know what I think until I see what I draw"), and c) the therapist. Art offers *a safe way* to communicate harrowing experiences. In order for things to be communicated veterans must feel *safe and comfortable* which appeared to be an amalgamation of feelings of *trust* and having *control*.

As part of the viewing and discussing each others' work, more often than not there will be *points of recognition*, i.e., similarities between works of art between group members or within one person over time. This strengthened already built *trust* further and aided the process of communication.

At the end of an art therapy session, whatever needed to be communicated was *made concrete*. It can now be kept *as a record of the personal journey* and it *can't be changed* but looked at *from different angles*. Some veterans used the artwork to aid communication outside the art therapy session including other therapies.

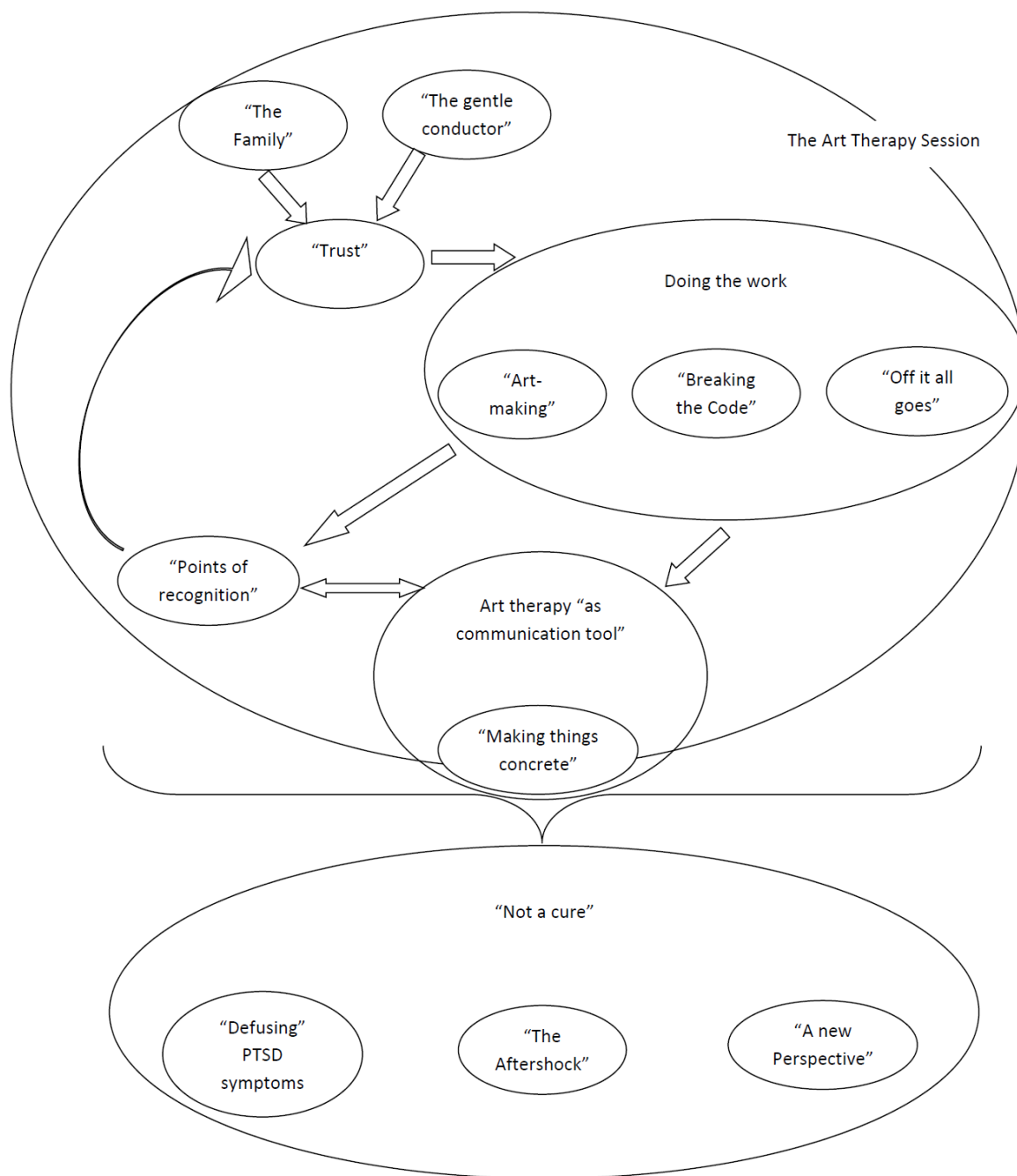
It is important to note that art therapy is not a cure. It has the potential to *defuse PTSD symptoms* including support in managing the condition. Veterans talked about a certain transience of effects and for most, difficulties re-emerge after some time.

Veterans found *opening up* as opposed to bottling up and avoiding particularly helpful. Some talked about having *less fierce nightmares* following art therapy. Most valued the opportunity to *get out of social isolation* and many felt *more relaxed/at ease*. An element of *emotional release* was reported counter-acting built up negative affect. Some even spoke of *defusing the memory* or a traumatic event thus moving it from a trauma to an ordinary memory.

In addition, veterans reported *a new perspective* gained through art therapy. This entailed a viewing themselves differently (*more compassionate; better understanding*) and their *future*. Veterans no longer felt *alone* and felt more able to *share the pain*. They also reported a *sense of achievement* which they may not frequently experience in their day-to-day lives.

Finally, participants experienced an *aftershock* of both emotional and physiological reactions. The *aftershock* ranged from feeling *fluffy/fuzzy*, over *tired*, to *drained*, and sometimes *panic*. Some stated that this might be linked to the aforementioned *emotional release*.

Please refer to the attached figure for a diagrammatic illustration.



Appendix M: Feedback Letter for Participants



Dear participant,

Re: Feedback from my research

You might remember taking part in my interview study on the mechanisms of change in art therapy. I am writing you today to feed back some of the results from my research.

You are probably aware that PTSD is a fairly common mental health difficulty in veterans. In the UK recommended treatment usually consists of cognitive-behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) but not everybody can benefit from those types of therapy and they have been found to be less effective for veterans. That is why it is important to establish whether other therapies can help veterans with their difficulties, too. Some previous research has suggested that art therapy can lead to positive changes in people with PTSD. Some have argued that this might be due to the non-verbal nature of the therapy as some find it difficult to access their traumatic memories with words and others might not wish to talk directly about their experiences as part of mainstream talking therapies. I was interested to hear how veterans experienced art therapy and what some of the active ingredients were from their point of view.

In total, I interviewed nine veterans, two art therapists, and a wife of a veteran. I used a methodology called grounded theory which is used to develop a model or theory based on interview data. The model was produced based on veterans' interviews but it was by and large corroborated by responses from art therapists and a spouse.

There appeared to be three main components of art therapy: 1) *the family* 2) *the gentle conductor* and 3) *doing the work*. *The family* or art therapy group is defined by its *size* and it has explicit and implicit *ground rules*. It was described as a *select group* whose members shared a range of similarities (a) *on the same wave length*, b) *military background*, c) *similar problems*, d) *a shared goal*). However, some differences were acknowledged such as a) being at *different stages* and b) having a *different approach to the work*. Similar to a well-functioning family, within the art therapy group members can learn from each other and support each other through difficult experiences. The second main component

was *the gentle conductor* or the art therapist. The *gentle conductor* was *calm, non-judgmental*, able to *help veterans to open-up*, and to find *the right balance* between taking control and handing it over to the participants. The *gentle conductor* was responsible for: a) providing the theme/topic, b) providing the context, c) keeping the structure, d) support in reading the images, e) record keeping. *The family* and *the gentle conductor* appeared to be conditions for building *trust*. *Trust* in turn was an important requisite for constructive work. The final active component was doing the work. Art therapy is an *active and creative therapy*. It has a clear *here-and-now focus* and combines *verbal and non-verbal* elements. The art-making phase is a *private affair* and can be *therapeutic* in itself. What is produced are *heartfelt doodles* limited by a) *skills level* and b) *time*. The *subjects* range from *positive/happy*, over *deep and dark* to *horrible and nasty*. Participants described how *it just happens* and images seemed to come up *automatically* and *effortlessly*. Once the artwork has been completed the phase of *breaking the code* commences. In this phase participants *talked about their picture* and it is attempted to make sense of it or establish its *meaning*. This is a *group effort*. The final aspect of art-making was the category *off it all goes* subsuming a number of reactions to the work during the sessions encompassing *bodily*, cognitive (“gets your mind going”), and emotional reactions. When these ingredients came together in the right way, art therapy can be used *as a communication tool*. *It is easier to draw than to talk* and *a picture is worth a thousand words*. The language of the communication are *symbols, metaphors, and analogies*. As part of the viewing and discussing each other’s work, more often than not there were *points of recognition*, i.e., similarities between works of art between group members or within one person over time. At the end of an art therapy session, whatever needed to be communicated was *made concrete*. Some veterans used the artwork to aid communication outside the art therapy session including other therapies. It is important to note that art therapy is *not a cure*. It has, however, the potential to *defuse PTSD symptoms*. In addition, veterans reported *a new perspective* of themselves and their future gained through art therapy. They also reported *a sense of achievement*. Finally, participants experienced an *aftershock* of both emotional and physiological reactions.

Despite some important limitation of my research such as veterans having received other therapies and a fairly homogenous sample, the developed model was consistent with previously hypothesised mechanisms of change in art therapy. It was recommended to repeat similar studies at other sites and in others settings to establish the validity of the presented model.

I want to end by expressing my gratitude for taking part in my research project! Thank you for taking time to participate in the interview and for being available for any correspondence since then. I think the current project has contributed to the growing evidence around the usefulness of art therapy in the treatment of PTSD and might help for it be more accepted as a treatment of choice for those difficulties.

Once again many thanks and please do not hesitate to contact me per email (gs282@canterbury.ac.uk) should you wish to discuss the results of my study in more detail.

Gabriel Schnitzer

Appendix N: Sample Email Respondent Validation

Please note that this email has been edited to protect the anonymity of the participant.

It also covered other points irrelevant for respondent validation that has been edited out.

Dear Gabriel

I am sorry that it has taken me a while to get back to you, but I wanted to give you a selection of meaningful images to choose from, together with some explanatory information about the images that I hope will be useful. Please feel free to use as many or as few of them as you find useful, with the sole exception of the image with file name '2014-10-21 Mind and Body'. I have included this one for information, but it is already used in [art therapists]'s book [...], so it cannot be used for copyright reasons.

[...]

I read through your draft synopsis with great interest, and I found the diagram very clear and understandable. There is one thing that I would query, which is the statement, "What is produced are heartfelt doodles". This doesn't seem to allow for poems, prose or models, which are also produced in art therapy sessions (I have included some poems that I have written in art therapy sessions as examples). Perhaps the statement could be expanded to something like, "What is produced are heartfelt doodles, scribbled poems or stories, and simple but meaningful sculptures."

[...]

Best Wishes and Good Luck
[veteran]